RURAL HEALTHCARE NEEDS AND SOLUTIONS

Ways Urban and Rural Healthcare Providers Can Increase Rural Access to Care

BY HOMER H. SCHMITZ, PhD

Summary Many rural communities are finding it necessary to create innovative ways to make healthcare more accessible to their residents. Successful rural healthcare delivery systems require the resources of an institution willing to serve the rural healthcare market, a community wanting to improve its healthcare, and dedicated practitioners.

Physicians must be willing to see Medicaid and charity care patients. If physicians in the community are too busy or unwilling to accept indigent patients, the community may need more physicians. When the community recruits additional physicians, leaders must clarify that all physicians have a responsibility to serve indigent patients. As a result, a community-wide healthcare planning process is essential.

Because residents might not always be aware that they should receive certain routine healthcare services or how to access those services, the community must establish strategies to reduce this knowledge gap. Urban healthcare centers can help by bringing health screening services to the rural community and by providing health education programs. Providers can close another part of the knowledge gap by helping patients fill out the insurance forms required to receive payment and by helping them find and apply for indigent patient coverage.

To help solve the physician shortage problem in rural areas, communities can work with urban healthcare providers to purchase or start new practices in rural areas and then supplement the practices with additional primary care physicians or other healthcare practitioners.

Americans living in rural areas often find that high-quality healthcare is inaccessible. This is because the manner in which healthcare was delivered to rural areas in the past is changing. In his article, "Surviving in Rural America," Robert Ludke, PhD, states, "As the environment changes, so must the entities within that environment. . . . When the environment changes, providers must reevaluate and reframe basic underlying assumptions."[1] After examining those assumptions about the delivery of healthcare in rural America, Ludke suggests that "the questionable validity of these assumptions implies that the current infrastructures for delivering rural healthcare services may no longer be appropriate. Thus rural communities must work to develop a viable and appropriate infrastructure that ensures access to high-quality, affordable healthcare services."[2]

The problems in delivering adequate healthcare to rural America are multifaceted.[3] Sometimes patients cannot obtain high-quality healthcare. Some services are not available in all locations, and some patients will be shut out of the system even when services are available. Health policymakers believe a major part of the problem relates to the inappropriate distribution of healthcare providers, both institutional and private practitioner. Institutional healthcare providers see the access problem as a question of economic viability because they cannot afford to provide all the expensive and high-technology services available in urban centers. Individual practitioners have other concerns, such as location and quality of life. Together, these limitations can create serious

Dr. Schmitz is associate professor, School of Public Health, St. Louis University, St. Louis.

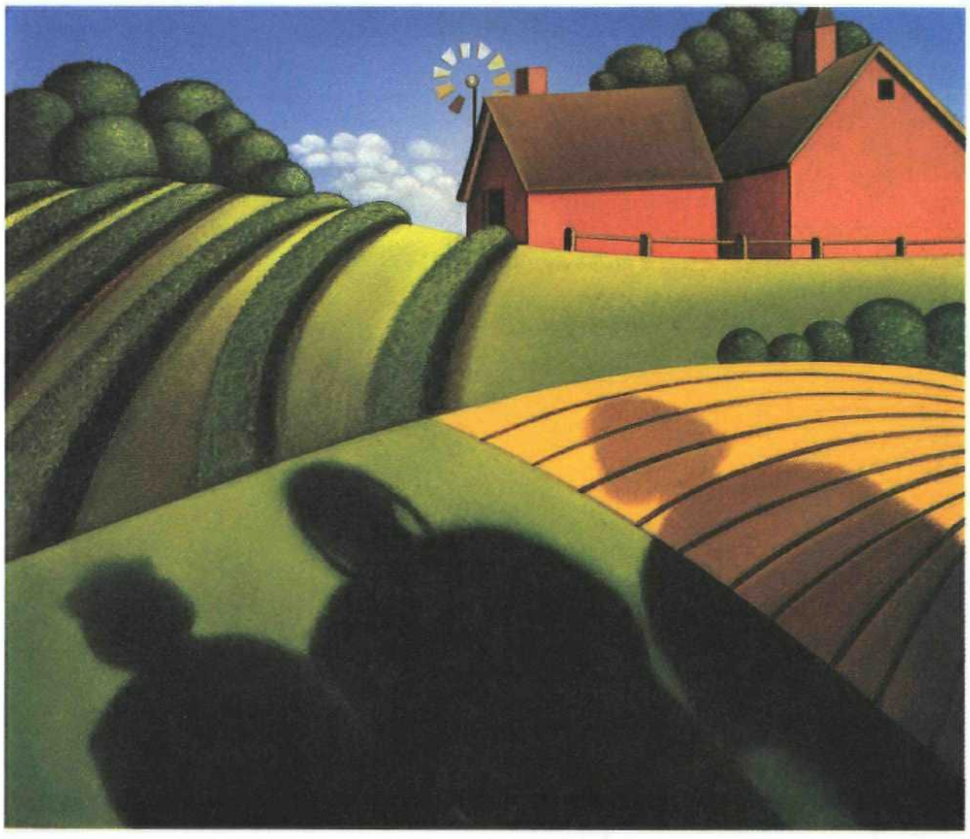
shortages of healthcare availability in rural areas.

Patient Access

Four types of rationing can limit a person's access to healthcare. Rationing occurs on the basis of economics, availability, knowledge, and location (see **Box,** p. 40).

One Approach to the Problem

Successful rural healthcare delivery systems require the resources of one or more institutions willing to serve the rural healthcare market, as well as dedicated practitioners willing to provide services in rural locations. The problems encountered in delivering healthcare to rural areas are much different from those in urban areas, and institutions undertaking this assignment must recognize the uniqueness of the task. As Dr. Ludke suggests, new and innovative approaches to delivering high-quality healthcare in a rural setting must be found to replace the old ones.[4]



Griesbach/Martucci

Communities throughout the country have undertaken numerous approaches, with varying degrees of success. Innovative rural residents will find some combination of the approaches cited below useful in addressing the various forms of rationing in their community.

Reducing Economic Rationing Although no single organization can solve the problems of an entire service area, a stable entity, whether it be a hospital or a large physician group practice, can make significant inroads. Physicians have taken the following approaches to significantly reduce economic rationing in some service areas:

- Physicians in the community must be willing to receive Medicaid patients, since this is the only payment option for large segments of the medically underserved population.
- Physicians in the community must be willing to receive some specified number of charity care patients who do not qualify for Medicaid coverage.

A correlation exists between the number of Medicaid patients or charity care patients a physician accepts and the practice's excess capacity; that is, if scheduled patients do not fill all the office hours, some physicians are willing to accept Medicaid patients and charity care patients who may be able to make a partial payment because at least some contribution is made to overhead expenses. Economics are not the only basis a physician uses in deciding to accept patients; however, when that criterion is applied, busy physicians are unlikely to replace their full-paying patients with those who are only able to pay part of the bill.

> Successful rural healthcare delivery systems require dedicated practitioners willing to provide services in rural locations.

If the physicians in a community are already busy and are unwilling to accept indigent patients, the community may need more physicians. When a community recruits additional physicians, existing physicians must be part of the planning process. In addition, community leaders must clarify that to maintain balanced practices in the community, all physicians—not just the ones being recruited—have a responsibility to serve indigent patients.

If existing physicians can see additional patients but choose not to treat indigent patients on some philosophical or economic ground, the community faces the difficult task of trying to help the physicians understand their responsibility to the community. This can be accomplished when a community establishes a planning process that involves all the affected parties, including the physician. Education and moral suasion can be a powerful ally in setting new directions for a community.

Reducing Knowledge Rationing Because residents might not always be aware that they should

receive certain routine healthcare services or how to obtain those services, the community must establish strategies to reduce the knowledge gap.

Most rural communities have potential access to a broad range of services available from larger institutions in surrounding urban areas. Because healthcare is becoming more competitive in urban areas, many urban healthcare facilities seek to establish closer ties with rural communities. In this way they may increase referrals to their urban facilities when patients from rural areas are hospitalized. As a result, many urban healthcare organizations, particularly medical schools, are willing to provide a wide array of services to rural residents. The community, including the physicians, hospital (when present), general public, and employers, must be involved in planning whether only tertiary referrals are sent to the urban center or whether other acute care hospitalizations are involved.

Solutions sometimes available to resolve some of the access problems resulting from lack of knowledge are:

- Urban healthcare centers bringing health screening services to the community and promoting them so residents know they are available.

Many urban healthcare organizations are willing to provide a wide array of services to rural residents.

- Community leaders establishing a speakers' bureau that addresses public health, clinical, and administrative issues such as insurance coverage. Insurance coverage discussions should include how to file an insurance claim, what coverage is available from the various payers, and how to obtain coverage such as Medicare and Medicaid.
- Hospitals (and more recently physician practices) helping patients fill out the insurance forms required to receive payment. For example, sometimes elderly Medicare patients need help understanding the Part B Medicare insurance form. Many organizations assist the patient while building a relationship of trust. In communities where this help is unavailable, community planners should try to provide it.

Reducing Location Rationing Many organizations have reduced residents' healthcare access problems that resulted from location. Throughout the United States these efforts have been spearheaded by hospitals and multispecialty clinics in urban centers, as well as by the local communities themselves. The motivation for hospitals and clinics to address location rationing springs from competition among healthcare organizations and the desire to preserve and enhance their patient refer-

TYPES OF RATIONING

Economic Rationing

Economic rationing occurs when funds are unavailable to pay for healthcare services, either because a person is uninsured or underinsured or because he or she has no money. Even though most healthcare providers offer charity care, a provider's ability to offer free care is limited.

Availability Rationing

Sometimes services are simply unavailable, regardless of location or the person's ability to pay. For example, in major organ transplant procedures a finite number of organs are available nationwide. Although patients frequently travel long distances and often are willing to pay for the procedures themselves, once the supply is exhausted, the procedures are unavailable. One could argue that availability rationing of many kinds of healthcare services occurs in rural areas and in economically depressed urban areas, but this confuses availability rationing with location rationing (see below). The difference is subtle but important. Availability rationing occurs because not enough services are available in the total healthcare delivery system regardless of location or ability to pay.

Knowledge Rationing

Knowledge rationing occurs when persons are simply unaware that they should seek medical help or when they know they need help but do not know how to acquire it. Sometimes people do not understand that prenatal care, rectal examinations, Pap smears, and other preventive measures are important to maintaining a healthy life. People who do understand this still may not know how to access the healthcare delivery system. For example, some do not know how to apply for Medicaid or charity care.

Location Rationing

Location rationing occurs because healthcare is unavailable in a certain location. This is most prevalent in isolated rural areas and in economically depressed urban areas. Although the other types of rationing occur in rural areas, they apply equally to urban areas; however, location rationing is more prevalent in rural areas because both practitioners and institutional healthcare delivery systems are maldistributed.

Another aspect of location rationing is that rural healthcare facilities tend to be small and offer a limited range of healthcare services not only because of the enormous expense of high-technology equipment, but also because the skilled specialty physicians necessary to use the equipment are often not available. In addition, a shortage of other healthcare professionals is also common. When left unchecked, expenses for high-technology equipment and the shortage of healthcare professionals have a self-limiting effect on the rural healthcare institution, which in some cases has led to closure.

rals. Because the issue is central to long-term viability, it is also part of many organization's mission.

When a community believes it is unable to solve the problem itself, residents must seek an alliance between the community's healthcare facility, its practitioners, and an urban healthcare organization. In other situations, part of the strategy to address this issue can include unilateral community actions. In either case, the community needs a systematic healthcare plan, and it must recognize that solutions to this complex problem evolve primarily by consolidating all the

Continued on page 72

REGIONAL CANCER RURAL OUTREACH PROGRAMS

Residents with cancer who live in the rural areas of southern New York and northeastern Pennsylvania have access to the care they need through the Regional Cancer Rural Outreach Programs sponsored by Our Lady of Lourdes Memorial Hospital, Binghamton, NY. The hospital offers this network of rural oncology clinics through its Regional Cancer Center, which serves an area population of 400,000.

Four outreach oncology clinics operate within a 40-mile radius of Our Lady of Lourdes Memorial Hospital. In 1982 two of the clinics were established at small hospitals (fewer than 100 beds). Two more clinics were established in 1987, one at a small hospital, the other at the office of a physician group. The four clinics handle approximately 1,200 outpatient visits or treatments each year in the rural five-county area. Patients requiring radiation treatments or specialized testing not available at the outreach clinics go to the Regional Cancer Center in Binghamton for these services.

Board-certified medical oncologists and oncology nurses staff the outreach clinics. They provide patients' initial consultations and disease management services such as chemotherapy and biotherapies, follow-up care, and referrals to specialized medical services. Home healthcare is also available. In addition, two of the clinics provide nursing services.

The Regional Cancer Rural Outreach Programs enable physicians practicing in remote areas to consult on patient treatment and follow-up with Our Lady of Lourdes board-certified cancer specialists. An added bonus is that rural residents do not have to travel long distances to get the treatments and healthcare services they need.

Through lectures and printed materials, patients and their families can learn more about the disease and treatment options. Regional Cancer Center staff, physicians, nurses, and oncology social workers offer periodic lectures to area residents and healthcare professionals to educate and update them on the latest trends in cancer detection and treatment. Patient and family education sessions are structured to meet the patient's needs on the basis of his or her disease, disease stage, and available treatment options. Clinic nurses distribute educational brochures published by the National Cancer Institute, the American Cancer Society, and Regional Cancer Center staff.

The cancer care services delivered to this rural area encompass the comprehensive services that have been available at Our Lady of Lourdes Memorial Hospital for more than 30 years. The hospital's Regional Cancer Center treats approximately 85 percent of all area patients newly diagnosed with cancer. Its services include radiation oncology, chemotherapy, hospice, detection and diagnosis technology, and a National Cancer Institute-approved clinical research program. The cancer center also offers patients and their families the support services of an oncology social worker, patient and family support, and pastoral counseling. *–MH*

Coming in the Next Issue of

Health Progress

Long-Term Care

In the special section, Brian E. Forschner, PhD, describes how senior living community administrators can create a deep sense of community for residents and staff. Two articles on care management describe programs in New Mexico, Colorado, Michigan, and Arizona that ensure their clients have access to a continuum of services. And two Catholic Health Association surveys examine the pressures and perspectives of chief executive officers in long-term care facilities.

The Economics of Physician-Hospital Relationships

Sr. Geraldine M. Hoyler, CSC, advises Catholic providers to view changes in the payment system as a way to improve how they meet people's needs, rather than as a time to introduce further fragmentation of services in an already fragile delivery system.

A Volunteer Parish Nurse Program

The parish nurse responds to the needs within the church congregation by providing a variety of services. Terry F. Buss, PhD, describes a volunteer parish nurse program at St. Elizabeth Hospital Medical Center of Youngstown, OH.

RURAL HEALTHCARE NEEDS AND SOLUTIONS

Continued from page 41

resources available in a community.

A dual approach to location rationing includes (1) bringing high-quality primary care physicians, specialty physicians, and other healthcare practitioners to the area and (2) making specialty and subspecialty services available in other innovative ways when it is infeasible to secure such physicians on a permanent basis. These two approaches have developed in a variety of forms. Programs that have been successful in various parts of the United States include the following:

- Existing practices in the community can develop various forms of working relationships with hospitals and clinics in urban areas. For example, an existing practice can work out a referral relationship with various specialists in return for gaining immediate access to specialty care for patients in the community.
- Hospitals or clinics in urban areas can purchase or start new practices in rural areas and then supplement the practices with additional primary care physicians or other practitioners.
- Hospitals or clinics in urban areas can provide specialty physicians who periodically travel to the underserved community to see patients who have been referred by community healthcare professionals. With this approach, sick patients will not have to travel long distances to urban areas for specialty referral services.
- The federal government has developed funding programs to pay for physician education. At the conclusion of the education the physician is usually obligated to work in an area that is medically underserved. More innovative communities might seek to establish such a relationship directly with a medical student. The community would pay for the student's education in return for his or her establishing a practice in the community upon certification. This is a particularly attractive approach when an area resident returns as a physician. Other alternatives for physician recruitment include the community establishing relationships with urban hospitals (particularly those associated with medical schools) or large urban clinics. These institutions are more likely to know of a medical student with the qualifications to match the community's needs.
- For specialty services that cannot be rendered in the local area, the community can establish a referral program. Patients can be referred to urban tertiary healthcare organizations and specialty practitioners that minimize patient inconvenience and render services promptly so that the patient can return to local practitioners as quickly as feasible.

Making Inroads

These innovative approaches become possible when the rural community and an urban healthcare provider have shared goals. These solutions to a community's healthcare needs can produce a synergistic effect when the collaboration results in a greater number of services being offered than any of the entities could have offered alone. Although the approaches outlined here might not always be optimal, they can certainly make significant inroads into the healthcare access problem for rural residents. □

NOTES

1. Robert L. Ludke, "Surviving in Rural America," *Health Progress*, September 1991, p. 60.
2. Ludke, p. 63.
3. Joseph P. Newhouse, "Geographic Access to Physician Services," *Annual Review of Public Health*, 1990, pp. 207-230; American College of Physicians, "Access to Health Care," *Annals of Internal Medicine*, May 1, 1990, pp. 641-661; David A. Kindig and Hormoz Movassaghi, "The Adequacy of Physician Supply in Small Rural Counties," *Health Affairs*, Summer 1989, pp. 63-76; Avi Dor and John Holahan, "Urban-Rural Differences in Medicare Physician Expenditures," *Inquiry*, Winter 1990, pp. 307-318; Robert A. Rosenblatt and Denise M. Lishner, "Surplus or Shortage? Unraveling the Physician Supply Conundrum," *Western Journal of Medicine*, January 1991, pp. 43-50.
4. Ludke.