Center for Rural Affairs
Walthill, Nebraska

Rural Health Care Task Force Report

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This report was prepared by a task force appointed by the Center for Rural Affairs Board of Directors. The members are:
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Data Gathering

The task force met three times and reviewed reports and/or received testimony from representatives of the Nebraska Office of Rural Health (Department of Health), the Nebraska Association of Hospitals and Health Systems, the Rural Health Advisory Commission, the Nebraska Rural Development Commission, The Nebraska Rural Health Association, and the Health and Human Services Committee of the Nebraska Legislature.

Commission

To assess current rural health care cost and quality in Nebraska and recommend changes that (1) provide reasonable access to all rural Nebraskans; (2) improve the range and effectiveness of health care services available in rural Nebraska.

Principles

The foundation for good health care begins with the individual. There is a broad public interest in encouraging personal health maintenance and healthy lifestyles.

The community and the public sector have responsibilities as well. First, we must provide preventive health care and public health education. We must assure that all people have access to health care services at a reasonable cost, and that health care is delivered in a way that responds to the consumer's needs, and not in a way that reflects the financial interests of providers. Insurance systems in particular must provide access to all.

At the same time, we believe that users should pay for health care, but that inability to pay should not exclude people from a reasonable level of care. Moreover, people should not be discriminated against on the basis of where they live, with respect to either accessibility or affordability.

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Findings

The state has an important role to play in rural health care. Despite substantial involvement of the federal government, the state determines the essential aspects of public health care; regulates health

care insurance, and the practice of health care by professional providers; allocates Medicaid funds; and should assist communities in local health care planning.

Access to Service

Rural Nebraskans are better served with health care than many Americans. Still, there are large gaps in our health care system.

Rural and urban areas of Nebraska have about the same percentage of the population uninsured, roughly 10 percent. Most of the uninsured in rural Nebraska are between the ages of 18 and 30. However, the rate of ***underinsurance*** is higher in rural Nebraska. Underinsurance exists when premiums are high, coverage is weak, and co-payments and deductibles are high.

A smaller percentage of those eligible for Medicaid receive benefits in rural areas than in urban areas of Nebraska. This affects not only the rural elderly, but young and low-income working families. For example, 27 percent of all births in Nebraska are paid for by Medicaid.

It is now likely that federal health care reform will leave large gaps in protection for the uninsured, the underinsured, the working poor, and the self-employed, all of whom are disproportionately represented in rural communities. It is these groups about whom we have greatest concern with respect to health care access.

Rural Need for Doctors

Rural areas are starved for primary care givers. About 60 communities are seeking doctors. Specialization of practice among doctors increases the minimum population necessary to support a physician, and encourages them to move to larger urban medical centers. Rural doctors are more likely than urban doctors to be planning to leave their practice in the next ten years.

Some doctors exploit community incentive packages by practicing for a minimum number of years, then leaving. Some communities spend large sums recruiting doctors which leaves them insufficient funds to support operations of a hospital or make new capital investments in health care.

Greater Role for Non-Doctors

Rural communities will have to depend more and more on mid-level professional primary care providers, such as physician's assistants and nurse practitioners, and even on emergency medical technicians (EMTs, most of whom are volunteers). Unfortunately, physician assistants and nurse practitioners are severely limited in their practice by requirements of a practice agreement placing them under the supervision of a physician. This offers little to improve the health care provided by these professionals and limits their outreach to underserved communities.

Many rural communities in Nebraska are well served by volunteer EMT units. In many instances, these are among the most viable organizations in the community, involving people from diverse segments of the community in service to everyone. These units are increasingly pressured to perform more service, to undertake more training (on their own time and at their own expense) and to accept greater responsibility. These pressures wear on current volunteers and can discourage new ones.

Moreover, these units are not supported by local taxes, which means that they must engage in continuous volunteer fund raising efforts to purchase equipment and to support their own service work.

Managed Care Systems

It is becoming clear that more health care will be delivered to rural Nebraskans through ***managed care systems***. Managed care systems are combinations of providers -- primarily physicians and hospitals -- who cooperate to provide a coordinated system of care.

Increasingly, these systems employ health care professionals on a salary or other fixed cost basis. This development is in response to pressure from larger, more sophisticated health care consumers, especially major corporations, who resist paying for physicians or other care professionals on a "fee" basis. These larger consumers have the bargaining power to pay less. Managed care systems can put together a package of medical services that respond to large blocks of consumers.

Anti-Trust Concerns

Managed care systems may cut health care costs and so they have been encouraged by relaxation of anti-trust laws that might have prevented health care providers from cooperatively pricing health care services. There are two threats in this exemption.

First, there is the possibility that large, centralized systems will ignore small, less profitable consumer groups (people in small communities). In some instances, these systems may behave bureaucratically to deny or discourage participation by rural people. Rural people in the periphery of service areas, especially those near the state border, may be required to consume services in distant locations within their own state, rather than more accessible locations in a neighboring state.

Second, these systems may effectively exclude certain providers who might better serve rural areas (such as nurse practitioners) from providing services through the system or from providing those services on compensation terms that are equitable.

Role of Rural Hospitals

At the same time, there is a merger and acquisition trend among hospitals with larger hospitals acquiring ownership of smaller rural hospitals. This means that more managed care systems serving rural areas will be centered in urban hospitals.

It also means that the role of rural hospitals is changing. Many are not only "downsizing," but providing a different, more limited, and less complex range of services, some as satellites of urban hospitals. In this, they may compete with physician clinics in some instances. At the same time, more of the full-service rural hospitals that persist in trying to compete on their own can be expected to fail in the years ahead.

Finally, Nebraska has a very meager public health system, almost none at all in smaller rural communities, and it has too little capacity to engage rural communities in planning for their own health care. The legislature has enacted regional health planning that authorizes rural communities -- with an emphasis on consumers -- to engage in health care planning, but it is a voluntary process and no funds have been appropriated to support it.

Recommendations

Although there are many issues that invite action, we believe that top priority should be placed on three, not necessarily in this order:

- trauma planning
- regional health planning
- scope of practice

These priorities are chosen because these issues address the problems identified in our findings, are currently the subject of policy discussion, and are of broad importance to many rural communities.

Trauma Planning

The federal government has mandated that each state develop a plan for the delivery of trauma care services. These plans may include significant changes in regulations governing emergency medical services. In rural areas, the EMS depends largely on trained volunteers and their own fund raising efforts. We are concerned that the regulatory framework be sensitive to volunteer needs, that it allow communities the flexibility to provide the level of emergency care services they are capable of mustering, and that minimum standards for training not be raised so high that volunteers are discouraged from participating.

Some rural communities may be able to provide advanced standards of emergency medical services with either paid personnel or volunteers willing and able to undertake extended training, but many cannot. A community should be able to choose the level of trauma care it is capable of providing, and be required to meet the training requirements of that level only.

Furthermore, we believe that legislation should be considered to allow local areas the option of a voter approved taxing authority to support local emergency medical services.

Regional Planning

Statutes adopted by the Legislature which allow regional health planning should be funded at a level necessary to support locally based planning. The statutes should be amended to mandate that every area of the state be included in a planning region with the discretion of local authorities to decide which region they wish to join.

These planning agencies should be consumer controlled, with appropriate participation from providers. They should be required to develop a local plan to include a minimum of five levels of health care to serve their communities:

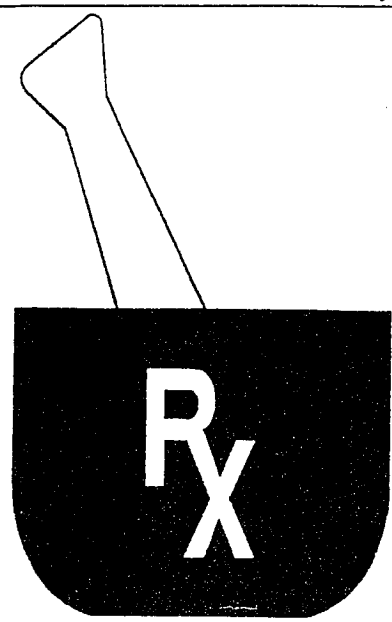
- Primary care
- Preventive care
- Acute care
- Emergency medical services
- Long-term/in-home care

These local agencies should be empowered with authority to grant independent practice rights to

mid-level professional primary care providers (nurse practitioners and physicians assistants), to approve certificates of need for medical facilities, and to allocate Medicare expenditures.

Scope of Practice

To increase the number of primary care providers serving rural communities, nurse practitioners should be provided the option of practicing independently, without a practice agreement with a physician. Moreover, managed care systems should admit to practice within the system "any willing provider" who wishes to be included.



Key Reforms for Rural Health Care

Trauma Planning

- allow communities to provide the level of emergency care services appropriate to their resources and needs
- maintain minimum training standards that encourage volunteer participation

Regional Planning

- include every area of the state in a planning region; one chosen by local representatives; and consumer controlled
- develop a local plan to include primary care, preventive care, acute care, emergency medical services, and long-term/in-home care
- allow local planning agencies to grant practice rights to nurse practitioners and physician assistants

Scope of Practice

- give nurse practitioners the option of practicing independently
- admit any willing provider to the managed care system