The Top 10 Rural Issues for Health Care Reform

a series examining health care issues in rural America

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Rural people and rural communities are faced with many of the same health care issues and challenges confronting the rest of the nation—exploding heath care costs, large numbers of uninsured and underinsured, and an overextended health care infrastructure. However, there are numerous unique health care issues facing rural people and rural places. This is surely not an exhaustive list of those issues; it is our view of the Top 10 rural issues that should be addressed in health care reform legislation. As the debate over federal health care system reform takes place in Congress, we hope this list can be used as a checklist against which any bill or policy proposal can be measured to determine its value and effectiveness for rural America.

An Economy Based on Self-Employment and Small Businesses

The rural economy is unique in its composition, making issues of uninsurance and underinsurance more prominent in rural areas. Since the late 1990s, rural areas have witnessed a significant decline in manufacturing jobs and a rise in service sector employment, losing jobs with higher rates of employer-sponsored health insurance while gaining jobs with much lower rates of employer-sponsored coverage.[4] The lack of employer-sponsored health insurance is particularly acute for low-skilled jobs, which are more common in rural areas.[4]

The rural economy is largely based on self-employment and small businesses. Since 1969, the number of self-employed workers in rural areas has grown by over 240 percent (by comparison, rural wage and salary workers witnessed only a 61 percent growth over the same period).[5] With an economy dominated by small businesses and self-employment (as well as seasonal and "patching" employment), rural people are generally less insured, more underinsured, and more dependent on the individual insurance market. While rural residents have higher rates of uninsurance, the existence of underinsurance may be as large an issue. There are twice as many underinsured in rural nonadjacent areas (those areas not adjacent to a metropolitan area) as in urban areas, and the challenges faced by the underinsured are ultimately similar to those of the uninsured.[6] Rural nonadjacent residents are responsible for nearly 22 percent more of their total health care costs (premiums and out-of-pocket costs) than are urban or rural adjacent residents.[6] Further, the odds of rural nonadjacent residents being underinsured are 70 percent higher than for urban residents, suggesting the "actuarial value of private health plans held by rural residents is lower than for urban residents."[6]

Any health care reform provision that relies exclusively on maintaining the current employer-sponsored health insurance system will not be as relevant for rural areas because of lower rates of employer-sponsored insurance and the composition of the rural economy. Issues related to underinsurance must be addressed for health care reform focusing on achieving universal coverage and access to health insurance to be relevant to rural areas. And the problem is exacerbated as health insurance premiums rise and out-of-pocket medical expenses increase, resulting in more and more self-employed and small businesses dropping unaffordable coverage for themselves and their employees or resorting to higher deductible insurance with less coverage. Any health care reform legislation must provide options—including a public option—to small businesses and the self-employed that provide comprehensive, affordable, and continuous coverage in ways that are comparable to larger group coverage. A key policy issue in this regard is how insurance is made affordable for those who need assistance with the cost. The details of any proposed subsidy plan will be crucial for rural people and small businesses because issues of affordability and cost is more acute in rural areas due to reduced ability to pay. How subsidies are structured and who receives them are fundamental issues affecting rural areas for both private and public health insurance options.

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Public Health Insurance Plans: Dependence and Need

With a population that is older, poorer and with less employer-based health insurance coverage, a larger segment of the rural population is dependent upon public health care programs such as State Children's Health Insurance Programs (SCHIP), Medicare and Medicaid. The number of rural non-elderly residents covered by public health insurance programs has increased by nearly 122 percent since 1987; nearly a third more rural people are covered by public plans compared to urban residents.[4] Yet many rural people and businesses are not eligible for these public programs.

Some health care reform proposals speak to providing tax credits to purchase private insurance as a method of addressing issues of health insurance cost and accessibility for small businesses and the self-employed, particularly in rural areas.

However, research has shown that using tax credits to purchase private insurance is not cost effective. Estimates from a national model show tax credits cost between $2.36 to $12.98 per dollar of insurance provided. The cost of expanding public health programs ranges from $1.17 to $1.33 per dollar of insurance value provided. The cost of expanding public health programs is thus two to 11 times more cost effective than providing subsidies through tax credits to purchase private insurance.[7] The cost ineffectiveness of tax credits is attributed to the poor targeting of credits. Credits to employees are less effective than those to employers since the greatest determinant of insurance is being offered insurance by one's employer.[7]

Viable health care reform legislation should strengthen those public programs currently depended upon by many rural people. The inclusion in health care reform legislation of a public health insurance plan and the option of individuals, families and businesses to choose such a plan potentially addresses many of the health care challenges faced by rural people, particularly small business employers and employees and the self-employed. Public insurance has a history of health care cost controls; Medicare, for example, had about a 60 percent less health spending per enrollee than did private insurance between 1997 and 2006.[22] Public insurance has also pioneered payment and quality-improvement methods that both control costs and improve the quality of care. This has happened primarily because public plans are public – unlike private insurance companies, public health insurance plan data and information is open to public research.[22] A strong public health insurance plan would also provide needed competition to private plans. The strengths of public health insurance plans are what many rural people and businesses need—stability and cost controls while providing health insurance access to vulnerable populations like low-and moderate income families, small business employers and employees and the self-employed.[22] As Jacob Hacker states, the choice between private and public health insurance plans is not an either-or proposition. Rather, they are complimentary and both are needed for a high functioning health care system that provides coverage for all. A system that provides the choice of public or private health insurance plans "serve simultaneously as a safety valve and a spur for improvement …"[22]

A Stressed Health Care Delivery System

The health care infrastructure in much of rural America is a web of small hospitals, clinics and nursing homes (frequently attached to the hospitals) often experiencing significant financial stress. Many rural hospitals have financial margins too narrow or too low to support investments in critical plant and technological upgrades.[8] Medicaid and Medicare reimbursement rates remain generally below actual costs of services provided, thus stressing providers that depend on reimbursements from public programs. The promise of federally qualified health centers across rural America has yet to materialize, thus affecting the available care for low-income and uninsured rural people. And many rural long-term care facilities are at risk of closure, affecting the health care safety net for the rural elderly.[3, 9]

The financial stress on the rural health care system is in large measure an expression of public policy. It is estimated that Medicaid and Medicare account for about 60 percent of rural hospital revenues; both programs are subject to legislative and administrative decisions and state and federal budgets that may result in declining

hospital revenues.[6] It is also estimated that nearly half of those classified as underinsured are facing collection or other legal action for their medical debts, causing a domino effect of financial stress for rural families and health care providers and facilities.

Health care reform legislation should address the plant and technology needs of rural health care facilities, provide resources to expand health care facilities such as federally qualified health centers to unserved or underserved rural areas, and address the current health insurance model that causes financial stress for rural families and rural health care providers.

Health Care Provider and Workforce Shortage

More than a third of rural Americans live in Health Professional Shortage Areas.[10] Nearly 82 percent of rural counties are classified as Medically Underserved Areas.[4] Only nine percent of America's physicians practice in rural areas.[11] Most rural areas in the nation have a shortage of practicing physicians, dentists, pharmacists, registered nurses, and ancillary medical personnel. And trends in this regard are not improving. For example, the number of rural counties designated as either whole or partial county dental shortage areas increased by nearly 160 percent from 1981 to 2005; now nearly 60 percent of rural counties are designated as dental shortage areas.[4] Only three percent of recent medical students are planning to practice in small towns and rural areas.[12]

The medical professionals that do practice in rural areas are also aging. Nearly 30 percent of rural registered nurses are over 55; the median age of rural physicians is 48. More than half of rural general surgeons are over 50, and the nation is producing essentially the same number of general surgeons now as in 1980. Of the cohort of clinically active physicians who graduated from medical school from 1988 to 1997, only 11 percent practiced in a rural area.[13]

Many national and professional trends work against rural areas. Factors such as the decline in the number of family physicians and primary care physicians, the increasing number of women in medicine, the lifestyle preferences of younger physicians and the increasing amount of student debt all negatively affect rural health professional recruitment.[10] The rural dependence on primary care physicians is a major long-term concern. According to the Journal of the American Medical Association, only two percent of medical students plan to go into a primary-care practice.

All of these workforce shortages exist despite the fact that, in general rural people have greater medical care needs than do nonrural people.[4, 14] A lack of family physicians that care for families from birth to death in every medical aspect, the so-called "medical home," leads to a lack of poor preventive care that results in more serious (and more expensive) medical problems down the road. Health care reform legislation will need to address promotion of rural medical practice, incentives to practice in rural areas and recruitment and education for all forms of rural health care professionals. Perhaps as importantly, new methods of financing health care must not contribute to a worsening of the rural health care shortage by providing even more economic disincentives to rural, primary-care medical professionals.

An Aging Rural Population

Many rural areas of the United States are experiencing significant demographic shifts, chief among them an aging population. In 2007, approximately 15 percent of rural residents were 65 years of age or older, 25 percent greater than in the nation as a whole.[1,2] The nation's population of those 65 or older is predicted to double by 2030, reaching 20 percent of the nation's total population, and the fastest group age cohort in rural America are residents 85 and older.[2] An increasingly aging population leads to greater incidences of chronic diseases and disability, taxing an already stressed rural health care system. An aging population also brings with it numerous social and community issues. For example, nearly a third of rural Minnesotans 65 years of age and older reported being limited in activities due to physical, mental or emotional problems.[3] A large portion of rural seniors live at home alone, without a spouse or family caretaker to provide or obtain necessary health care services.

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While seniors have nearly universal health care coverage due to Medicare, there are certainly issues related to rural seniors that should be addressed in health care reform legislation. Providing health care services in community settings that allow rural seniors to remain in their communities (through rural health clinics and federally qualified health centers, and critical access hospitals), addressing rural health care worker shortages, enhancing Medicare funding of telemedicine and other health care information technology uses in more health care facilities frequented by rural seniors, and strengthening long-term care services and supports are examples.

A Sicker, More At-Risk Population

The Center on an Aging Society at Georgetown University summarizes the health status of the nation as this: "The rural population is consistently less well-off than the urban population with respect to health."[14] More rural people have arthritis, asthma, heart disease, diabetes, hypertension and mental disorders than urban residents. The differences are not always large, but they are consistent—the proportion of rural residents with nearly every chronic disease or condition are larger.

The Kaiser Commission on Medicaid and the Uninsured found that despite an older population and higher rates of disability in rural areas—which *should* require *higher* health care needs—rural residents actually receive comparable or less care in many measures, suggesting rural residents may not be receiving adequate care. For example, rural residents receive fewer regular medical check-ups, blood pressure checks, cholesterol checks, pap tests, and mammograms than they medically and statistically should.[15] The ultimate result of less than adequate care is a worsening of health status and an increasing of chronic conditions—exactly what has been found.

Despite an array of health care differentials between urban and rural people, there is evidence that the ultimate health status of rural people has much to do with health insurance coverage and the type of health insurance coverage. There is evidence that rural people with employer-provided health insurance obtained more and less costly health care services than those with privately-purchased health insurance.[15,21] Insurance that provided better coverage at lower cost, therefore, resulted in more—and presumably regular and better—health care services. Unfortunately, as discussed above, many rural people lack such coverage.

Individuals and families are also at greater risk of higher premiums or being denied coverage when pre-existing conditions exist, which are more likely to exist among rural people due to higher rates of most chronic diseases and conditions and higher rates of disability among rural people. While some states prohibit coverage discrimination based on health status, most do not. Current federal law prohibits discrimination based on health status in group plans but not for individual plans that are also more common in rural areas. Health care reform legislation should act to enhance and promote health, but it should also remove barriers to affordable health insurance coverage. Barriers such as denial of insurance for pre-existing conditions have a potential disproportionate affect on rural people and should be addressed in health care reform legislation.

Need for Preventive Care, Health and Wellness Resources

A growing body of research documenting problems in nutrition and activity in rural areas has found that rural residents generally fare worse than their urban counterparts in regards to obesity, which is opposite to the situation that existed prior to 1980.[16]

No one explanation appears satisfactory for why problems with nutrition, activity and weight are so prominent in rural America. In spite of this uncertainty, it is critical to consider some of the most widely discussed factors, most of which concern the environment of modern rural living. The relative lack of nutritious food in many rural food system; challenges to and decreases in physical activity, especially among rural children; fewer people employed in agriculture and other physically rigorous occupations; strong social networks may actually reinforce unhealthy eating and sedentary behaviors; and a deficit in health education in rural areas are all factors leading to worsening

health situations in rural areas.

Perhaps the most important reasons working against rural areas in regards to obesity and general health concern demographics. Rural residents are older, less educated and poorer than urban residents. All of these demographics increase the risk for obesity.[16]

Health care reform policy should do more to enhance and promote health and wellness in order to prevent major health conditions and their long-term costs. Rather than being satisfied to provide affordable and accessible health insurance to address "sickness," we should also develop a real "health" care system.

For a more in-depth discussion of this issue see our paper *Nutrition, Physical Activity, and Obesity in Rural America* at http://files.cfra.org/pdf/Nutrition-Physical-Activity-and-Obesity-in-Rural-America.pdf.

Lack of Mental Health Services

Over half of the counties in the United States have no mental health professionals, a situation that has changed little in 45 years. Mental health or behavioral health issues are estimated to take 20-25 percent of primary care physician's workloads, taxing an already stressed system of medical care.[1] Research has shown that for rural patients in need of mental health care, general medical care only is significantly more likely and specialty mental health care is significantly less likely to be given.[17] Since patients receiving care in the specialty mental health sector are substantially more likely to receive adequate care than patients receiving care in the general medical sector only, this indicates that rural individuals are receiving poorer quality care.[17]

Public policy has done little to address major sources of this rural disparity—the need for mid-level professionals to provide mental health services and a marketplace for such services. Health care reform legislation can begin to address these disparities by providing incentives and reimbursement mechanisms for mid-level mental health providers (providers at the Bachelor's and Master's degree level) in rural areas and by providing resources for a specialty mental health marketplace similar to what exists for rural medical clinics.

Increasing Dependence on Technology

Medical providers are increasingly employing health information technology to improve patient safety, quality of care and efficiencies. However, adoption of health information technology has remained slow in rural areas. For example, a consortium of rural health research centers has shown that while 95 percent of critical access hospitals have computerized their administrative and billing functions, only 21 percent employ forms of electronic health records.[18] Use of telehealth applications by rural providers are also mixed. Eighty percent of critical access hospitals use teleradiology, yet only 24 percent employ telepharmacy services.[18]

Several barriers exist in rural areas to the expansion of health care information technology. Broadband and high-level telecommunications technology coverage in rural areas is a significant barrier. Without a national commitment to provide accessible and affordable broadband and high-level telecommunications technology in all rural areas, rural use of health information technology will likely remain limited. Capital resources are also constrained for rural health care providers. Often rural providers have to choose between medical equipment, building improvements and technology resources. Rural areas often have difficulty in recruiting and retaining information technology professionals, particularly in small hospitals, clinics and physician practices. The Agency for Healthcare Research and Quality has identified physician resistance to health information technology as a barrier to rural use. Many rural physicians believe more technology will negatively affect productivity and workflow, and additional reliance on technology is often financially impractical for small offices and providers.[19]

Congress and states must begin to address rural disparities in accessible and affordable broadband and high-level telecommunications technology in order to realize the full potential of health information technology.

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Health care reform legislation should include the resources, incentives and education necessary for the enhanced use of health information technology by rural providers.

Effective Emergency Medical Services

Emergency medical services (EMS) are often the first-line medical and health care providers in rural areas. For many of the demographic and health care system issues outlined here, EMS have had placed on them growing demands and health care responsibilities. At the same time, many rural EMS providers are underfunded and facing workforce and volunteer shortages.

The National Conference of State Legislatures has outlined other issues facing rural EMS. Many EMS providers have inadequate communications infrastructure and are thus often isolated from the rest of the health care delivery system. A major example is the lack of access EMS providers have to medical records and medical history, something health information technology could potentially resolve if EMS providers were able to obtain the resources to connect with other rural providers.[20]

Another identified EMS issue is the lack of integration of EMS into the rural health care system. An integrated system will provide more efficient patient referrals, a reduction in costs, improvement of medical services, and a broader primary care and public health model in rural areas. Of course, integration has its challenges in rural areas, chiefly communication over wide geographic areas and EMS reliance on volunteers.[20]

Health care reform legislation can recognize the important role EMS providers and services provide in rural communities, particularly by recognizing EMS as a part of the health care delivery system and by providing resources to such services for enhanced communication technology and access to health information technology.

References

[1] Rural Assistance Center, http://www.raconline.org/info_guides/aging/

[2] United States Administration on Aging, *Statistics on the Aging Population*, 2007.

[3] Office of Rural Health and Primary Care, Minnesota Department of Health. *Health Care Reform: Addressing the Needs of Rural Minnesotans*. 2007.

[4] National Advisory Committee on Rural Health and Human Services. *The 2008 Report to the Secretary: Rural Health and Human Services Issues*. 2008.

[5] Goetz, Stephan J. 2008. "Self-Employment in Rural America: The New Economic Reality." *Rural Realities*, Vol. 2, Issue 3, 2008.

[6] Ziller, Erika C., Andrew F. Coburn, and Anush E. Yousefian. 2006. "Out-of-pocket Health Spending and the Rural Underinsured," *Health Affairs*, Vol. 25, No. 6, 1688-1699, 2006.

[7] Gruber, Jonathan and Ebonya Washington. 2005. "Subsidies to Employee Health Insurance Premiums and the Health Insurance Market," *Journal of Health Economics*, Vol. 24 (2, Mar.), 253-276.

[8] Critical Access Hospitals Financial Indicators Team Report. 2006. *CAH Financial Indicators Report: Summary of Indicator Medians by State*. Chapel Hill, NC: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research.

[9] N. Rehkamp. 2006. *Mapping the Future: Enhancing LTC for Older Minnesotans*, 2005 to 2030. Minneapolis, MN: LarsonAllen.

[10] Rabinowitz, H.K., James J. Diamond, Fred W. Markham, and Jeremy R. Wortman. 2008. "Medical School Programs to Increase the Rural Physician Supply: A Systematic Review and Projected Impact of Widespread Replication," *Academic Medicine*. Vol. 83, No. 3, 235-243, March 2008.

[11] Gazewood, J.D., Rollins, L.K. and Galaska, S.S. 2006. "Beyond the horizon: The role of academic health centers in improving the health of rural communities, *Academic Medicine,* Vol. 81, 793-797.

[12] Association of American Medical Colleges. 2006. *Association of American Medical Colleges Matriculation Questionnaire 2005: All Schools*. Available at http://www.aamc.org/data/msq/allschoolsreports/msq2005.pdf.

[13] Chen, Frederick M, Meredith A. Fordyce, Steve Andes, and L. Gary Hart. 2008. *U.S. Rural Physician Workforce: Analysis of Medical School Graduates from 1988-1997*. Seattle, WA, The University of Washington Rural Health Research Center.

[14] Center on an Aging Society. 2003. *Rural and Urban Health*. Washington, DC: Georgetown University.

[15] Kaiser Commission on Medicaid and the Uninsured. 2003. *The Uninsured in Rural America*.

[16] Tai-Seale, Tom and Coleman Chandler. 2003. "Nutrition and Overweight Concerns in Rural Areas: A Literature Review." *Rural Healthy People 2010: A companion document to Healthy People 2010, Volume 2*. College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.

[17] Western Interstate Commission for Higher Education. 2008. "Assessment Of The Mental Health Funding Marketplace In Rural Vs. Urban Settings." Available at http://www.wiche.edu/mentalhealth/ResearchCenter/research.asp.

[18] Flex Monitoring Team. 2006. *The Current Status of Health Information Technology Use in CAHs*.

[19] Agency for Healthcare Research and Quality. *Health IT in Small and Rural Communities*. Available at http://healthit.ahrq.gov/portal/server.pt?open=514&objID=5554&mode=2&holderDisplayURL=http://prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k_o/knowledge_library/key_topics/health_briefing_09202006031947/health_it_in_small_and_rural_communities.html. Accessed February 10, 2009.

[20] National Conference of State Legislatures. 2000. *Emergency Medical Services in Rural Areas: How can States Ensure Their Effectiveness?* Denver, CO: National Conference of State Legislatures.

[21] The Access Project. 2008. *2007 Health Insurance Survey of Farm and Ranch Operators*.

[22] Hacker, Jacob S. 2008. *The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage*. Berkeley, CA: Center on Health, Economic and Family Security, University of California, Berkeley School of Law.

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