DEATH BY A THOUSAND CUTS
RURAL HEALTHCARE IN DECLINE

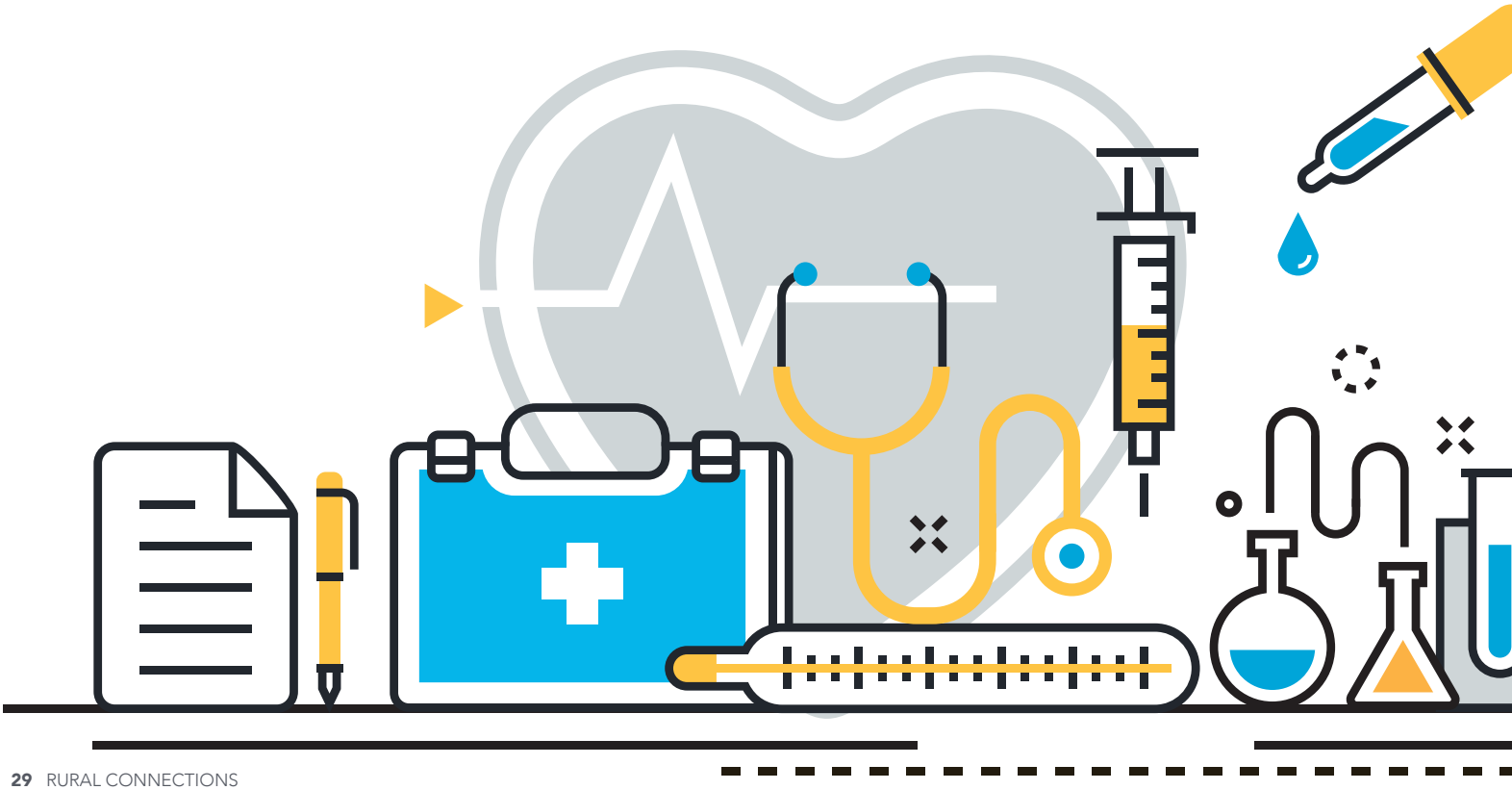
By Elizabeth Zach - Rural Community Assistance Corporation (RCAC)

During the past several years, hospitals that serve small rural communities across the nation have closed their doors at a disquieting rate, essentially one per month. Some towns never recover from the economic blow of a hospital closure: with no nearby hospital, businesses are hesitant to locate to the area.

Economics and demographics work against small hospitals that provide care in remote, often impoverished areas. Declining populations, more elderly and uninsured patients, expensive equipment, few specialized services and treatments, and demand for more emergency and urgent care, neither of which bring in much revenue – all have contributed to rural healthcare's death by a thousand cuts. For states that have not expanded Medicaid under the Affordable Care Act, declining reimbursements have been particularly onerous.

It is also difficult to recruit and keep primary care physicians in rural areas, especially younger physicians who prefer urban settings; which creates a bleak outlook for hospitals that serve rural populations.

For rural residents, the concerns are more immediate: How far is it to the nearest emergency room? What if I have a serious illness and need frequent treatment over many months? Will my insurance be accepted at another hospital and pay for other doctors?



"Declining populations, more elderly and uninsured patients, expensive equipment, few specialized services and treatments, and demand for more emergency and urgent care, neither of which bring in much revenue – all have contributed to rural healthcare's death by a thousand cuts."

These are just some of the repercussions from rural hospital closures.

In 2010, researchers at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill began monitoring rural hospital closures nationwide (http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/); as of February 2017, there were 80. The center warns that nearly 700 more are vulnerable to closure in the coming years. The majority are critical access hospitals with fewer than 25 beds that serve communities more than 35 miles from the nearest hospital.

In addition, the opioid crisis in rural America has been linked in part to a lack of care. Most rural communities do not have treatment centers, drug recovery programs, and behavioral health specialists. And, when the nearest health care facility is far away and ongoing treatment and follow-up care are unavailable, the potential for opioid addiction is higher, say health experts.

In studying rural health care, Cristina Miller, an economist at the U.S. Department of Agriculture's Economic Research Service, points out that hospitals are large labor demanders, offering local jobs, both for high- and low-skilled workers, from nurses to janitorial services and maintenance.

"An employee buys a house in the area," Miller said, "brings their family with them and demands public goods. Their kids will go to school there, they'll buy gas and food there, money circulates. The idea is that there is spill over." According to a 2006 study, "The Effect of Rural Hospital Closures on Community Economic Health," in the journal Health Services Research, a rural hospital's closure "decreases the economic well-being of the community and likely places the local economy in a downward cycle that may be very difficult to recover from."

Two examples in rural California, which has lost three rural hospitals since 2010, illustrate the crisis. Across the eight counties that comprise the state's Central Valley, there are as few as two hospitals.

"There's a focus on California because it's an important state," says Maggie Elehwany, vice president of government affairs at the nonpartisan nonprofit National Rural Healthcare Association. "But also, people forget that it's largely rural, and that it's almost like several countries, with different populations and economies. This makes health care delivery very challenging."

Swedish immigrants settled the town of Kingsburg in the Central Valley in the 1870s, and today it is a Scandinavian Mayberry, with beautifully tended gardens on its main street intersections and hand-painted coats of arms alongside half-timbered building facades. When Kingsburg Medical Center closed in 2010 and in its place, a mental health clinic opened across from an elementary school, residents protested, claiming it posed a risk to the children. They also had to contend with uncertainty in medical emergencies. One resident recalls, shortly after the hospital closed, a harrowing 13-mile drive one November night in the Valley's notoriously dense fog to the nearest emergency room.

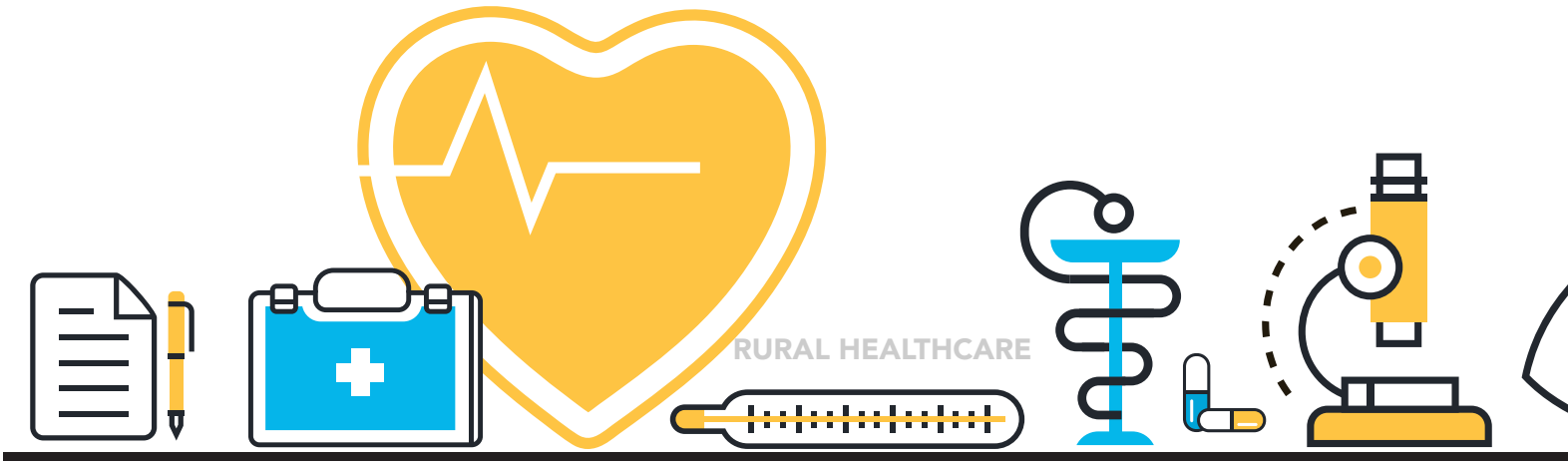
In Corcoran, about 30 miles south of Kingsburg and home to two prisons, city manager Kindon Meik describes losing out on two businesses in recent years that were looking to relocate to the town. Both reneged once they learned there was no nearby hospital. Corcoran District Hospital, which opened in 1949 and served the town of 25,000 until it closed in 2013, still has a website announcing that it is a "hospital with a heart" offering primary care "dedicated to family medicine," along with specialists in cardiology, podiatry, ophthalmology and general surgery. But in reality, residents travel to hospitals as far away as Fresno – 50 miles away – or Visalia – 30 miles away – for health care.

"Any business leader would want to know that there is a hospital nearby," Meik says. Moreover, with an aging population, assisted living facilities – which often work in tandem with hospitals – have also become part of the criteria for whether a business locates to a certain area.

In some cases, telemedicine – whereby a patient and nurse videoconference with a doctor instead of meeting face-to-face – can help. For initial intake and chronic ailments such as Hepatitis C, diabetes, and rheumatoid arthritis, the technology has helped rural communities access care.

At Redwoods Rural Health Center in tiny Redway, California – a four-and-a-half-hour drive north of San Francisco – clinical nurse manager, Sarah Foster, is enthusiastic about telemedicine's prospects. Her patients suffer from Hepatitis C, diabetes, thyroid abnormalities, and rheumatoid arthritis.

"These are chronic, long-term diseases, and we were, to be honest, overwhelmed and overworked with caring for these patients," says Foster, noting that Redwoods contracts with Telemed2u, located near Sacramento. "We have no specialty services around here." The clinic plans to expand telemedicine services to their psychiatric patients, she adds.



One significant drawback, however, is that many rural areas lack strong Internet connectivity to support the technology. Critics also argue that telemedicine does nothing to enrich a local economy in the way that a hospital does, providing jobs and a platform for community benefits, such as schools and increased property values.

Nor can telemedicine help with serious chronic diseases such as cancer, when frequent, lengthy and oftentimes debilitating therapies are critical to patient care. This is a dilemma both media and policymakers largely overlook– so much so, in fact, that in September 2015, the prominent journal Oncology published the first clinical overview of it.

The study, "Challenges of Rural Cancer Care in the United States," notes innovative methods for treating cancer patients in remote areas, including outreach clinics, virtual tumor boards (whereby specialists meet to discuss patients' diagnoses and therapies), and physician retention programs. The study points to the looming "projected increase in demand for cancer care due to the aging population."

According to the study's lead author, Dr. Mary Carlson, "Typically, a cancer center has social workers who see that patients are getting the support – emotional support, financial counseling – they need, or even transportation to treatments, organizing a place to stay. But in rural areas, there just aren't many social workers, period, let alone an oncology social worker, to connect patients to resources. That was probably the biggest eye-opening thing for me with the study."

Many rural areas lack not only oncology services but, more specifically, those for children. Some healthcare observers say that the business model for such care doesn't support pediatric oncology services in sparsely populated areas because the occurrence of childhood cancers is relatively rare. But parents whose children do suffer from the disease face long commutes to treatment facilities and uninsured travel expenses.

Rural healthcare's shifting landscape in the American West, the distressing clip of small hospital closures, and longer distances to reach medical care can have a profound effect on a community. Older residents can recall births and deaths at their nearby hospital, a camaraderie among nurses and doctors, peace of mind and even pride.

"It is almost like the town has given up on any hopes of ever having something in this community to attract more families to locate here," says Kathy Ebner, a nurse who runs a small clinic in Dos Palos, which lost its hospital in 2006. The median home price here is just $100,000; unemployment hovers at about 15 percent. "It is as destitute as you can imagine."

But, she stays.

"I have had many offers over the years to relocate, but I just can't walk away. The residents, the staff, they become part of your family. We have all at some point helped each other to raise children or bury a loved one. You just don't walk away from that."❊