On the Plight of the Rural Hospital

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Rural hospitals, which for many years have played a key role in providing adequate and accessible health-care services in remote areas, are more in jeopardy for their survival than ever before. Despite a strong national concern for increasing the supply of health-care manpower in rural areas, relatively little attention has been focused on stabilizing and preserving small rural hospitals. The viability of these hospitals is being increasingly compromised during the 1970s by a wide range of factors, including restrictive licensure, design, and construction requirements; reimbursement methods that discourage appropriate use of facilities; increasing overhead, without increase in bed utilization; and, spiraling costs of professional liability insurance, which have in some instances caused physicians to discontinue such services as obstetric and trauma care.[1]

This is a matter of serious concern for family practice, which necessarily provides the largest proportion of health-care services in rural areas. Family physicians need ready access to adequate hospital facilities in order to provide the range of services which are required in smaller communities and for which they have been trained.

In terms of health-care manpower, considerable progress is being made toward alleviating a critical shortage of health-care providers in rural areas. The rapid growth in the number of family practice residencies in the United States since 1970 has resulted in a substantial increase in well-trained family physicians. Over one half of the graduates of these programs have established their practices in communities with populations less than 25,000. Over ten percent of the 1977 graduates entered practice in communities less than 2,500 in population and more than 25 miles from large communities.* An increasing number of medical students and young physicians are viewing rural practice as an attractive career option through group practice and other developing support systems.

It is now well documented that most recently trained physicians strongly prefer partnership or group practice to solo practice.[2-4] There is also good evidence that professional isolation, overwork, and unavailability of techniques for enhancing the capabilities of primary care practice play an important role in career and location changes of primary care physicians, particularly in rural areas.[5] Since rural hospitals help to increase the professional interaction among physicians in more remote areas, facilitate continuing medical education, and expand the capabilities of primary care practice in rural areas, their loss would work

*Based on data compiled by Division of Education, American Academy of Family Physicians, Kansas City, Missouri.

against the progress being made in relieving the physician shortage in these areas.

The small rural hospital of 25 to 100 beds which is faced with increasing overhead, stable or declining bed occupancy, and heavy administrative and fiscal burdens has several kinds of options available, such as: (1) form an association with other rural hospitals; (2) form an association with a larger urban hospital; (3) contract for services of a management firm; (4) reduce the range of services provided; or (5) close the hospital. Clearly there is a broad range of circumstances represented by rural hospitals in different parts of the country, and the best course for any individual hospital to take to address its problems may involve various combinations of the above approaches as well as others. Basic to any effective approach, however, is the increasing need to develop new cooperative relationships on a regional basis.

One model which holds promise for many rural hospitals is represented by the successful experience of a regional consortium of hospitals in Washington State. Over the last five years, such a consortium has been developed and maintained linking Virginia Mason Hospital, a 293-bed acute care general referral hospital in Seattle, with nine rural hospitals ranging in size from 26 to 109 beds.[6] The major objective has been to share educational programs and services within the consortium. The autonomy of the participating hospitals is preserved, and each hospital is responsible for defining its own needs. The consortium is guided by a Steering Committee including the administrators of the participating hospitals, and acts as a "broker" to extend resources from the metropolitan hospital to the specific needs of individual member hospitals. In addition to continuing medical education and consultation/referral services, the consortium during the past several years shared expertise in such areas as medical records, laboratory, pathology, infection control, respiratory therapy, pharmacy, dietary, engineering, and business office and related management areas. The stability of this consortium after six years demonstrates that this voluntary system of cooperative relationships continues to meet the needs of the participating hospitals.

Regardless of the specifics relating to any given rural hospital's problems and solutions, two points are clear: (1) small rural hospitals must increasingly interrelate more closely with other hospitals and health-care professionals in order to be congruent with evolving patterns of health care in their region; and (2) the problems of rural hospitals and rural health-care providers (particularly physicians) cannot be addressed separately since they are mutually interdependent. In any given instance, the quality of patient care (including accessibility) and the welfare of the patient must provide the central basis for reassessment and planning of a rural hospital's future role, size, and range of services. Family physicians in rural areas must become actively involved in an ongoing dialogue among hospital administrators, regional planning groups, and others involved in the planning for future rural health-care services. This is not to argue that all existing rural hospitals should survive, but that mechanisms should be developed to assure the survival of those rural hospitals considered essential health-care resources within an accepted regional plan. Since many of the small rural hospital's problems are different in magnitude and kind from those of the larger hospitals in metropolitan areas, regulatory and reimbursement agencies must become educated to these special problems so that rational approaches can be developed which will assure the viability of the small rural hospital as a foundation of high-quality health care for the populations of rural areas.

References

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