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HEALTH CARE IN RURAL AMERICA

HON. TERRY L. BRUCE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 8, 1987

Mr. BRUCE. Mr. Speaker, this year Congress began work in reviving the health care delivery system in rural areas. But we have some hard work ahead of us. A 1986 study conducted by the University of Illinois School of Public Health and the American Hospital Association's Data Center indicated that a total of 83 hospitals closed last year. Over 50 percent of these were in rural areas. The total bed loss among closed rural hospitals was 106 percent higher than in 1985. In addressing rural health care issues we must ask why rural hospitals are in such dire straits.

Mr. Speaker, my experience in the 19th Congressional District of Illinois has brought into focus a few basic facts. First, rural hospitals face lower reimbursement rates from Medicare. In fact, payments under PPS are both inequitable and inadequate. On equity, rural hospitals are paid 17 percent less than their urban counterparts. On adequacy, I would point out that since 1984 the hospital's market basket has risen 12.5 percent while the rate of Medicare hospital reimbursement has increased by only 5.5 percent. Second, rural areas face greater difficulty in attracting physicians and other health care professionals for reasons that include high levels of uncompensated care and high proportion of Medicare and Medicaid patients. In addition, rural hospitals often do not have the resources to furnish all the medical equipment that physicians need to provide the quality of care that patients have come to expect. Third, the impact of hospital closings in rural areas extends beyond the loss of inpatient hospital services. Hospitals are often the second or third largest employer in a rural area and are a hub of economic and community activity. As much as 60 percent of a hospital's total outlays are dedicated to payroll and for each dollar that is earned by a rural hospital that dollar is spent between 1.5 and 3 times in that rural community.

A recent editorial by Professor Anthony R. Kovner in American Health Association News identifies six factors which contribute to rural hospital closures. The factors identified by Kovner mesh with my experiences in downstate Illinois. Mr. Speaker, I believe that all us concerned with the plight of rural hospitals will find this article to be of interest and would, therefore, like to include this article in the RECORD.

RURAL CLOSURES GO BEYOND PAYMENT—AND INTO THE TROUBLES OF RURAL LIFE

(By Anthony R. Kovner)

A 1986 study, conducted by the University of Illinois School of Public Health and the AHA's Hospital Data Center, indicated that a total of 83 hospitals closed last year, with 52.1 percent of those hospitals located in nonmetropolitan areas. Total bed losses among closed rural hospitals were 106 percent higher last year than in 1985.

Why do such rural hospital closures seem to continue unabated? Identifiable threats include:

Demographic factors. A low population density, worsened by the emigration of the younger population in search of employment in larger communities, results in a higher proprtion of elderly people remaining in rural communities. This elderly population is known to absorb a significant amount of health care services. A weak farm economy also decreases local tax bases and increases the proportion of rural Americans who lack adequate health insurance.

Utilization factors. Overall utilization of inpatient services in rural areas continues to decline, while those same services are increasingly utilized by the elderly who are covered by decreasing Medicare reimbursement. Consequently, rural hospitals reach base levels of fixed costs with high costs per case and low net operating margins.

Greater competition. Urban hospitals' solutions to declining utilization have included market expansion to adjoining rural areas, from which urban facilities attract mostly the younger population; access to urban hospitals often is difficult for the elderly, the poor and their families—who constitute a high proportion of the rural population and who are in greater need of services. These groups then tax rural facilities' resources.

Reimbursement changes. Although a large percentage of elderly patients utilize the acute care services available in rural hospitals, rural facilities are reimbursed at lower PPS rates than are their urban counterparts; also, rural hospitals do not usually benefit from teaching-facility adjustments to DRG payment.

Insufficient physician supply. Rural communities continue to experience difficulties in recruiting and retaining qualified physicians (mostly generalists and family practitioners). Although the total number of U.S. physicians may be sufficient—or more than sufficient—for the nation, there are shortages in many rural areas.

Technological changes. The rapid technological advancement in many areas of medical practice sometimes renders rural health care practitioners and rural hospitals technologically obsolete. Too frequently, facilities, equipment and training are no longer adequate to compete with those at urban hospitals.

There is no one strategy or solution to these problems. But policymakers must realize that rural hospitals have fewer resources than do their urban counterparts to adapt to change—and many needed rural facilities may require emergency governmental financial support to survive.

Anthony R. Kovner is a professor at New York (City) University's Graduate School of Public Administration and director of the Princeton, NJ-based Robert Wood Johnson Foundation's Hospital-Based Rural Health Care Program.

BOB DOLE'S PROBLEM

HON. LOUIS STOKES

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 8, 1987

Mr. STOKES. Mr. Speaker, on Sunday, November 15, 1987, the New York Times published an article written by Anthony Lewis entitled, "Bob Dole's Problem." Mr. Lewis is regularly featured on the editorial pages of the Times in his "At Home Abroad" column.

Mr. Lewis' article represents a sensitive discussion of political realities in South Africa and the impact of these realities on our electoral politics. I would like to bring Mr. Lewis' article to the attention of my colleagues in the Congress. The article follows:

[From the New York Times, Nov. 15, 1987]

BOB DOLE'S PROBLEM

(By Anthony Lewis)

BOSTON.—Senator Robert Dole is a formidable candidate for President: sensible, knowing in the ways of Washington, a conservative who has no time for the fantasies of Reaganomics. He has shed the meanness of the past, showing us instead a man with compassion for the dependent and rejected in society.

But when he formally announced his candidacy last week, there was one sour note, small but irritating. In Iowa, the first key state, television advertising and protesters waving signs objected to his position on South Africa, in particular his support for President Reagan's veto of economic sanctions last year.

Senator Dole was angry. "There's not a racist bone in my body," he said. I am sure he means that. But he has a problem here, a serious one. It is a problem of perceived insensitivity.

Not just on sanctions, but on a series of African issues, Senator Dole has lined up with the extreme right. He joined Jesse Helms in holding up the nomination of a new American ambassador to Mozambique as a way of pressing the Reagan Administration to deal with Renamo, the South African-supported guerrillas who carry out mass murders in Mozambique.

Last summer, in a letter to a Kansas constituent, Senator Dole denounced the African National Congress of South Africa, the outlawed anti-apartheid organization. He said the A.N.C. "espouses 'necklacing,' " the gruesome practice of killing suspected Government spies in the black townships by putting burning tires around their necks.