

Review & Commentary on Health Policy Issues for a Rural Perspective – January 1st, 2010

Canadian Lessons for Rural Hospitals

From the abridged version of the “Rural Physicians of Canada’s discussion paper on rural hospital service closures” by Peter Hutten-Czapski, MD, and approved by the Society of Rural Physicians of Canada, 4/09. The complete study is available at:

www.cma.ca/

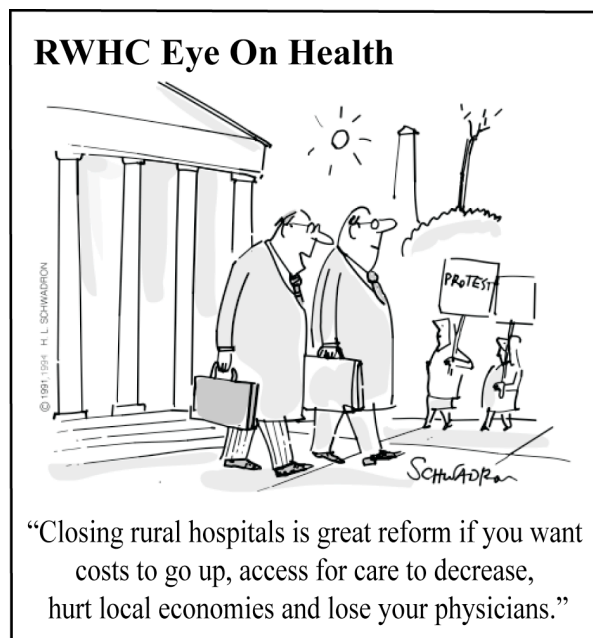
Introduction—“Although Canada’s beleaguered health care system still produces outcomes among the best in the world, there are growing signs that this is not the reality for Canadians living in smaller or more isolated communities across the country.”

“Despite manifest rural–urban health inequity, regional management repeatedly finds it an easy decision to close, or hobble, a small peripheral hospital and transfer a portion of the funding for those services to the centre of power.”

“This paper is an abridged form of the Society of Rural Physicians of Canada’s discussion paper on rural service closures developed to examine the arguments and evidence for hospital and service closures.”

“The ‘Quality’ Case for Hospital and Service Closures—Quality arguments for closures occur typically as veiled slurs on the rural institution that fly in the

face of the evidence. Maternity care has been found to be as safe in smaller rural hospitals as in large specialist-run centres in northern Ontario. American studies have shown that if women have to travel to give birth, costs are higher and results are worse. Because of the evidence of safer local access, large Canadian medical organizations joined to issue a statement on the need for rural maternity care in Canada with and without local cesarean capability.”



“Appendectomies done in western Canada by general practitioners in rural communities had slightly fewer complications than those done in city hospitals. Colonoscopies and other endoscopic procedures done by rural family doctors, when studied, are as high in quality as those done by specialists.”

“According to the Canadian Institute for Health Information all but 3 rare and highly specialized procedures are done as competently in low volume centres in Canada as

in high volume centres.”

“The Economic Case for Hospital and Service Closures—Conventional wisdom states that fewer hospitals ease administrative complexity and offer a potential for cost savings. Despite many rounds of restructuring, experiential evidence has not supported the assumption that even this 1-dimensional view of efficiency is achieved. The cost argument for the closure of rural hospitals rarely addresses the indirect

costs, such as those related to ambulance use, or personal costs related to transportation, hotel accommodation, meals away from home, accidents

getting to other communities and so on. When increased costs to the patient are assessed, total costs are found to increase. Even when you ignore such costs it is not clear that there will be savings from the closure of rural hospitals. Former Saskatchewan minister of finance Janice MacKinnon, reflecting back on the 1993 closure of 52 mostly very small rural hospitals, has estimated that only about \$30 million was saved, which is far less than what was expected.”

“The Manitoba Centre for Health Policy did an analysis of hospital efficiency in Manitoba correcting for varying case mix (different patients with different medical conditions) between hospitals. The most efficient hospitals in Manitoba were found to be the full-service medium-sized rural hospitals such as the 30-bed Beausejour Hospital.”

“The report suggested that the most cost savings, 11% of the provincial inpatient budget, could be achieved from improving the efficiency of the largest hospitals to the level of the larger rural hospitals.”

“This was not because the teaching hospitals were the most inefficient, but because they treated 35% of the inpatients and consumed 46% of the provincial inpatient budget. In contrast, although the smallest and

RWHC Blogs

The Rural Health Advocate: www.ruraladvocate.org/

Rural Health IT: www.worh.org/hit/

most isolated rural hospitals were relatively inefficient, they only consumed less than 1% of the budget.”

“In an analysis of the Ontario hospital closures of 1996/97, when Ontario went from 223 to 150 hospital corporations, short-term analysis failed to show monetary gains. The authors suggest that this paradox stems from unrealized potential gains, and the finding that large hospitals with high levels of tertiary care are ‘less efficient in the provision of outpatient and emergency care.’ This is not to suggest that there are no potential financial savings from system changes, but rather to point out that hospital service closure is a blunt instrument.”

“Regionalization and the Right Number of Hospitals and Services—There is no one ‘right’ decision as to what health services will be provided to whom and where. It varies by geography. There are several basic services that for population safety and access need to be as close as possible to where people live and work. By analogy, it doesn’t matter that fire halls are inefficient, as the vast majority of the time there is no fire to fight. That service is nonetheless needed in a timely fashion. Similarly, basic medical care is needed close to the patient.”

“Generally, emergency care, inpatient care and often obstetric care should occur when there is enough of a population base to sustain a complement of 5 or more physicians, which is a bit more than 5000 people. This makes the call burden sustainable for most of the professions involved, and also invokes a hospital size that is efficient. These services might need to be supported locally in communities with smaller populations if the next location that can provide this care is more than half an hour transport away. In Ontario the ministry has used 40 km as the distance between hospitals that have 24-hour emergency department coverage.”

“Closure by degree is sometimes supported by the argument that many of the emergency department visits are deferrable and could be seen by family physicians in their offices. This is true for all emergency departments, including those at large teaching hospitals.”

“There are other arguments that night volumes are so small that the emergency department should be

RWHC Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979, has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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closed after midnight. As with firefighting, the purpose of the infrastructure is to be available, regardless of the time of day, for the few cases in which timely intervention makes a difference. When those in central planning are contemplating closure of services, local consultation with providers and the population is essential. Closures must take the following elements into consideration:

- local economic conditions including the role that health care institutions and services play in the local economy
- geography
- effect on the retention and recruitment of health care professionals
- transportation, which includes everything from ambulance services, to public transportation, to the state of the roads or air services to the regional centres, as well as the effect of weather on the ability to travel
- ensuring that services such as home care, ambulance services and telehealth are available in communities from which hospitals or services are being removed
- equity of access”

“The Case Against Closures—Closure of rural community hospitals has documented repercussions. Studies show a lower quality of care, decreased access to physician services, fewer employment possibilities and increased per capita health care expenditure. If there is no other hospital in the community, per capita income can drop by 4% and the unemployment rate can increase by 1.6 percentage points. The largest impact of an imposed hospital closure is the impact on recruitment of new medical and nursing staff.”

“Fort Macleod is an Alberta town with a population of about 3000, situated 50-km west of Lethbridge. It’s at the crossroads of 2 major highways and in between 2 of the largest First Nation reserves in Canada. Before 2003 the 5 doctors who worked there supported a full-service hospital, including obstetrics and surgery. In 2003 the hospital was converted into Fort Macleod Health Centre with 3 holding beds and a limited emergency department. Within 1 year the 2

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www.rwhc.com (under Awards)

newest doctors, who still had between them 20 years in town, had left, and another doctor semiretired. Nurses and radiography and laboratory technicians began looking for positions elsewhere, or retired. Now

there is little to attract new physicians to the area. The town is continually trying to fill vacancies and has been consuming a significant portion of the provinces locum fund for rural doctors between 2005 and 2007.”

“In New Brunswick’s Upper St. John River Valley a regional hospital was built in 2007 between Bath and Woodstock to replace 3 other hospitals, despite massive demonstrations in affected communities. The Woodstock doctors had a vibrant full service hospital that was really a case example of how best to run a rural hospital. Since their hospital has been closed, the Woodstock doctors no longer provide inpatient care to the new hospital (except for obstetrics) as it is perceived as no longer being their hospital.”

“One of the unintended consequences is that the change undermined the ability for the region to recruit, since current New Brunswick legislation would require any new doctor to admit patients to the hospital without being able to sign out to local physicians. In the meantime the region is subsidizing itinerant physicians to provide this care.”

“Another example of the unintended results of closures is that downsizing can actually decrease efficiency. In Strathroy, Ont., closure of the rehabilitation beds has destabilized the hospital. Inpatients that were once rehabilitated to go home or were having their condition stabilized while waiting for a nursing home bed, are now decompensating and having to remain at the hospital as long-term patients. In the drive to save money, efficiency and patient care decreased.”

“Conclusion—The issue of service and hospital closures is highly emotionally charged. The local community has much to lose and little or nothing to gain. Closures are the easiest to arrange when there is an alternative institution in the community. Closures of hospitals that would result in populations needing to travel under half an hour for care may be reasonable, if by so doing, the existing health care providers

would agree to join together to form a larger group to share the burden of providing care.”

“Even if this were the case, it is not at all clear that efficiency would increase. The evidence that exists implies that without meaningful local input it is possible, if not likely, that costs will go up, access will decrease, and there will be negative ramifications for the local economy and for the recruitment of physicians.”

An Urban View of Rural: Glass Mostly Empty

From “Elderly in Rural Areas, Times Are Distinctly Harder” by Kirk Johnson in *The New York Times*, 12/10/09:

“Norma Clark, 80, slipped on the ice out by the horse corral one afternoon and broke her hip in four places. Alone, it took her three hours to drag herself the 40 yards back to the house through snow and mud, after she had tied her legs together with rope to stabilize the injury.”

“A dutiful farm wife, Ms. Clark somehow even got to her feet to latch the gate. And her first call when she got to the house was not to 911, but to a daughter 30 miles away.”

“‘I told her she’d better come feed the horses,’ said Ms. Clark, telling the story from her living room overlooking her 900-acre wheat farm.”

“Growing old has never been easy. But in isolated, rural spots like this, it is harder still, especially as the battering ram of recession and budget cuts to programs for the elderly sweep through many local and state governments.”

“Ms. Clark has been able to get help since her fall two winters ago because Wyoming, thanks to its energy boom, continues to finance programs for the elderly. But at least 24 states have cut back on such

programs, according to a recent report by the Center on Budget and Policy Priorities, a Washington research group, and hundreds of millions of dollars in further cuts are on the table next year.”

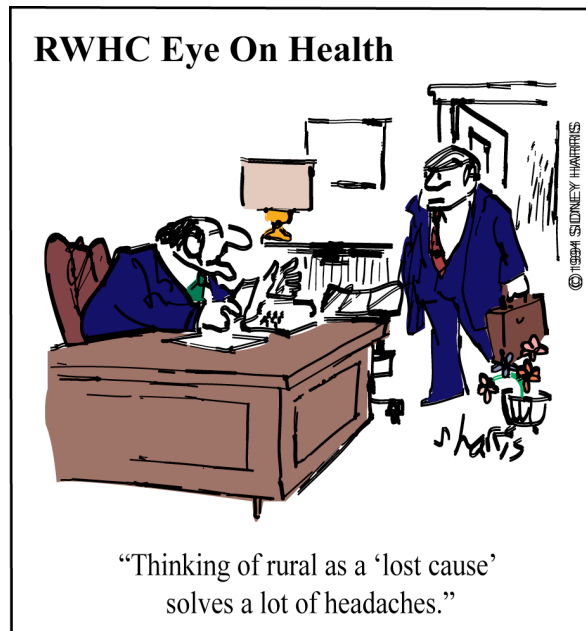
“The difficulties are especially pronounced in rural America because, census data shows, the country’s most rapidly aging places are not the ones that people flock to in retirement, but rather the withering, remote places many of them flee. Young people, for decades now, have been an export commodity in towns like Lingle, shipped out for education and jobs, most never to return. The elderly who remain—increasingly isolated and stranded—face an existence that is distinctively harder by virtue, or curse, of geography than life in cities and suburbs. Public transportation is almost unheard of. Medical care is accessible in some places, absent in others, and cellphone service can be unreliable.”

“Even religion and the Internet are different here. Churches have consolidated or closed—a particular hardship for older people, who tend to be avid churchgoers. And a lack of high-speed broadband service in many rural areas compounds the sense of separation from children and grandchildren, as well as the broader world.”

“The distance between friends is what gnaws most fiercely at George Burgess. Mr. Burgess, who has lived and worked for most of his 96 years in Wyoming and Nebraska as a hired farmhand and in later years as a machinist, still drives his truck almost every day into Torrington, Wyo., about eight miles from his home, for a lunch at the senior center. But his driver’s license

expires in January, and he is deeply worried that he might not pass the test this time around.”

“Mr. Burgess gets housekeeping assistance under a state program that helps older people stay in their homes and out of nursing care. But if he could not socialize in town, he said, he would be lost.”



“ ‘I might be on roller skates,’ said Mr. Burgess, still cowboy-thin in cinched-up Levis, his booming outdoor voice filling his home on a recent snowy afternoon. He glanced around the tiny, cluttered living room—the coal stove, the broken television, the walls lined with pictures of his wife, Laura, who died just over a year ago after more than 60 years of marriage.”

“ ‘I wish it was different, but it isn’t,’ he said. ‘So you endure it.’ ”

“Some people who study rural America say the tough economic times and new budget woes could make it too difficult for many rural stoics to hang on. But others suggest the fortitude of the rural elderly simply runs too deep for that.”

“ ‘The people will remain, because they’re rooted and anchored to the land,’ said Teresa S. Radebaugh, the director of the Regional Institute on Aging at Wichita State University. ‘They’ll stay no matter what.’ ”

“Verna Bairn, 67, is a farm widow who has lived all her life in Oshkosh, Neb., about 115 mostly empty miles southeast of Lin-
gle. She has seen the young people leave, she said, and the businesses on Main Street close. She has seen the median age in Garden County—where Oshkosh, population about 900, is the county seat—climb to 45 to 50 years old, according to the census, more than 10 years older than the nation’s as a whole. The counties in north-west Nebraska are now some of the oldest in the country.”

“ ‘One foot in the grave, the other sliding,’ said Ms. Bairn in describing her town. Ms. Bairn has a daughter in Wyoming and a

son in Wisconsin. Her husband, Edgar, died in 1998, of cancer, at 60.”

“ ‘He and I had one plan for our life, and God had another,’ she said of her husband’s early death and the personally hard times that followed. ‘We played our cards the best we could.’ ”

“It is in fact quite easy to find older people who take comfort in the surroundings they have known since they were young, however difficult things have become. Memory is everywhere, and hardship has been the norm in life, many say, so what’s new?”

“But an equally important reality, gerontologists and psychologists say, is that people who have managed to reach great age in a tough environment have, in turn, been toughened by the experience.”

“Some people, like Jesse Cardona, just never stop working. He chose the cowboy’s life in Wyoming, and, at 88, said he had the scars to show for it , including being kicked by a bull in the late 1970s.”

Six Things Have Come Together to Fracture Our Public Space and Paralyze Our Ability to Forge Optimal Solutions

From the OP-ED “Advice From Grandma” by Thomas Friedman in *The New York Times*, 11/21/09:

- “Money in politics has become so pervasive that lawmakers have to spend most of their time raising it, selling their souls to those who have it or defending themselves from the smallest interest groups with deep pockets that can trump the national interest.”
- “The gerrymandering of political districts means politicians of each party can now choose their own voters and never have to appeal to the center.”
- “The cable TV culture encourages shouting and segregating people into their own political echo chambers.”
- “A permanent presidential campaign leaves little time for governing.”
- “The Internet, which, at its best, provides a check on elites and establishments and opens the way for new voices and, which, at its worst provides a home for every extreme view and spawns digital lynch mobs from across the political spectrum that attack anyone who departs from their specific orthodoxy.”
- “A U.S. business community that has become so globalized that it only comes to Washington to lobby for its own narrow interests; it rarely speaks out anymore in defense of national issues like health care, education and open markets.”

“Mr. Cardona has worked on the same 30,000-acre ranch—since divided into two 15,000-acre sections—near Torrington, Wyo., for more than 42 years. He lives in a house provided by the ranch’s owners, for whom he still works mending fences in the summer.”

“ ‘I told them when I retire—no more cows, I’d had enough,’ he said. And he works only short days now, he said, six or seven hours, and spends the winters watching movies, preferably starring John Wayne, on his television.”

“ ‘I don’t get lonely,’ he said, sitting in his quiet kitchen.”

“Ms. Clark, the 80-year-old with the bad hip, said she did not suffer from the solitude either. Her chair is positioned to look through the big picture window that dominates her living room. On a clear day, you can see across her land and all the way, 60 miles or so, to Laramie Peak. It is a landscape drenched with the memory, she said, of her husband, Leo, who died last year after a long illness, and the six daughters they raised together on the land.”

“ ‘I sit, and I look,’ she said.”

Location Matters as Rural Loses & Gains Jobs

From “Alabama is Bleeding Rural Jobs: Rural Alabama has had the worst job losses in the country during this recession. Other parts of rural America have seen job gains. Location means everything” by Bill Bishop and Roberto Gallardo, 12/14/09 at: www.dailyonder.com

“This map shows the percent change in jobs in every rural and exurban county in the lower 48 states between December 2007, when the recession began, and October of this year.”

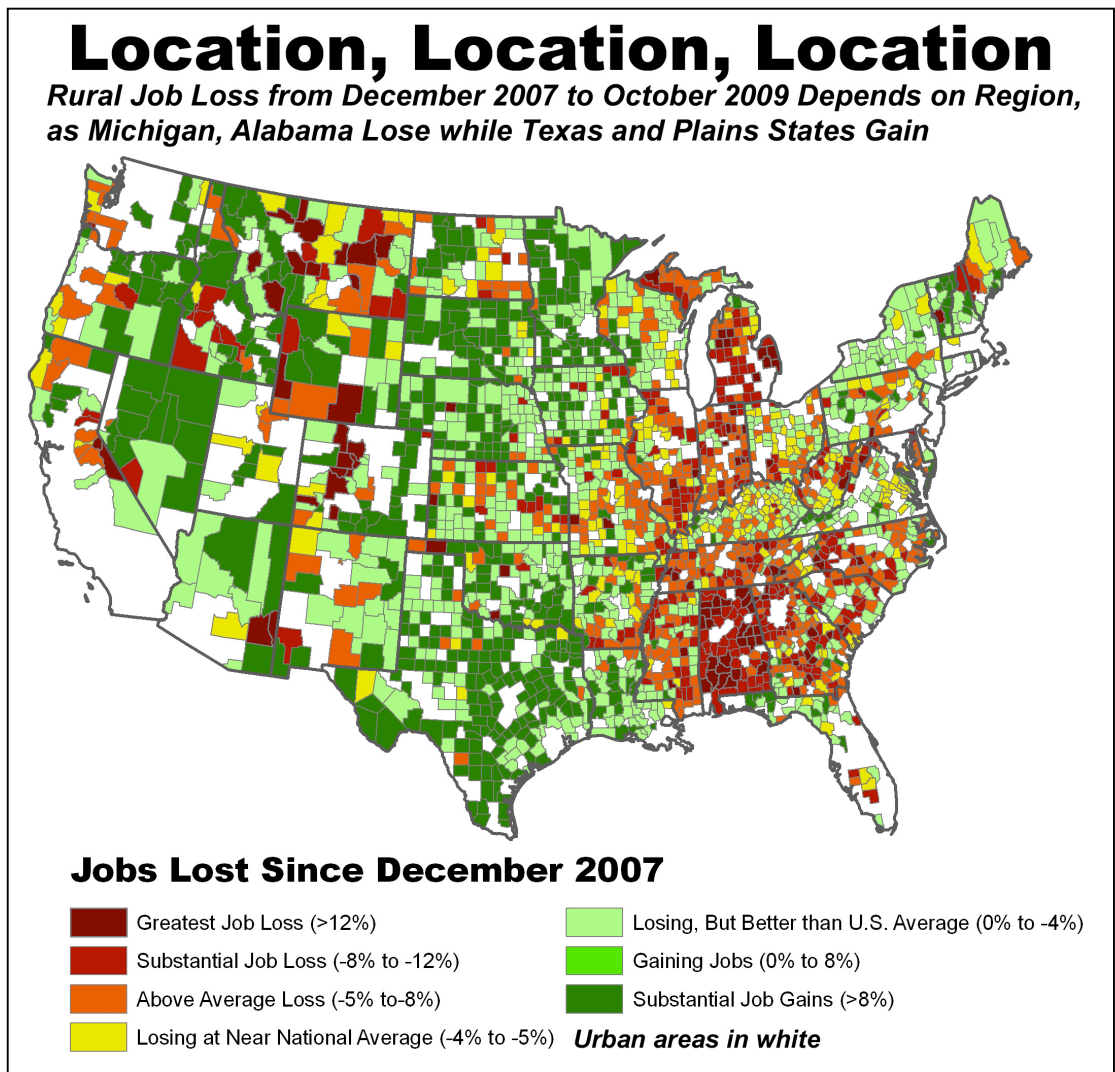
“No state has lost a higher percentage of its jobs since this recession began in December 2007 than Alabama. The state had 11% fewer jobs in October 2009 than it did in late

2007—a larger decline than even battle-scarred Michigan. The worst job declines in the nation during this recession have been in rural Alabama, which has 13.1% fewer jobs than when the recession began.”

“Nationally, rural America has fared better than urban or exurban counties in terms of job loss. Rural counties across the U.S. have lost 3.5% of their jobs. In the country as a whole, there were 4.5% fewer jobs in October of this year than in December 2007. In urban counties, job loss reached 4.7%.”

“National figures on job loss, however, miss the point. The face of this recession changes dramatically from place to place. In rural Utah, for example, there has been a nearly 5% increase in jobs in the last two years.”

“The map below shows the percentage change in jobs since December 2007 in rural and exurban counties



only. (To see a larger version go to www.dailyyonder.com). The dark green counties had substantial job gains (more than 8%) over the last two years. The dark reddish-brown counties had the greatest (more than 12%) job losses.”

“Yellow counties are near the national average in job loss, somewhere between -4% and -5%. There are very few average (yellow) counties. Most places in the rural and exurban U.S. fall far from the average, many gaining jobs and many losing. The hotspots for job loss are Michigan and, especially, Alabama.

“Both Michigan and Alabama are centers of automobile manufacturing. Michigan is the nation’s traditional auto making state, of course. But Alabama has become a top producer since 1993, when the first car plant, a Mercedes-Benz facility, announced it would open a car assembly plant in Tuscaloosa County.”

“A stream of other manufacturers followed. Alabama now ranks fifth in the nation in car production, and in 2005 the state said the auto industry accounted for 44,834 direct jobs and nearly 80,000 indirect jobs. Southern Business and Development magazine named Alabama ‘State of the Year’ for three years in a row.”

“Meanwhile, however, some parts of rural America have shown job gains. Rural Utah and Texas have registered gains in the last two years. Counties near military bases continue to show increases in employment.”

Rural Roads Major Health Hazard

From “The Deadliest Roads Are Rural” by Howard Berkes on National Public Radio. 11/29:

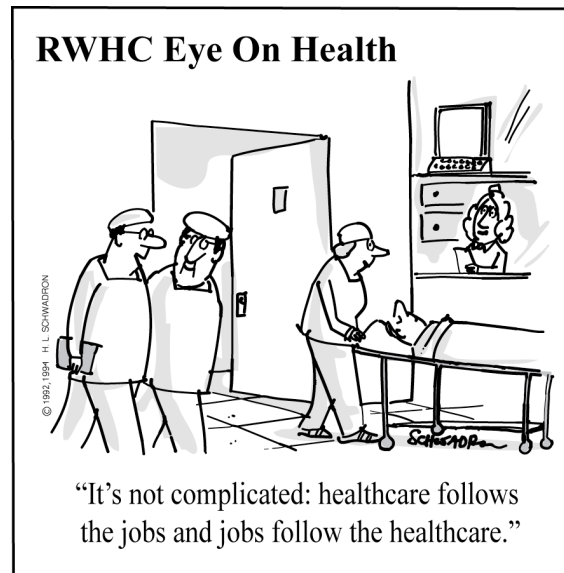
“Traveling over the river and through the woods this holiday season is not the safest way to get to Grand-



mother's house. The roads traveled least are the nation's deadliest roads, according to federal highway data. More Americans die on rural highways than on urban streets and freeways.”

“Last year, 56 percent of the nation’s 37,261 traffic fatalities occurred in rural areas. Yet rural America has just 23 percent of the nation's population. In some states, more than 90 percent of highway deaths occur on rural roads.”

“The grim statistics provided by the National Highway Traffic Safety Administration also show that drivers on rural roads die at a rate 2.5 times higher per mile traveled than on urban highways. Urban drivers travel twice as many miles but suffer close to half the fatal accidents.”



“This may seem counterintuitive, but highway safety officials and activists have plenty of explanations. People driving rural roads tend to drive faster. They drive without seat belts at higher rates. More of them drive and die drunk. When they're injured in accidents, they may not get timely emergency medical care given the remoteness of many rural roads. And, deer, elk, moose and other wild animals are more likely to dart out into traffic on rural roads.”

“Some experts note that the outdated design and layout of many rural highways are also factors. Driving errors that are manageable on urban roads become deadly on rural highways.”

“Victor Mendez, administrator of the Federal Highway Administration, notes that there is little room to recover if a driver makes a mistake on a rural highway. ‘That's simply because of the nature of rural highways,’ Mendez says. ‘The lanes are much more narrow. You look at trees and ditches. Chances are they're closer to the roadway than they would be on an interstate.’ ”

Community Care Brightens Days Ahead

We regularly showcase a RWHC member from the Wisconsin Hospital Associations' annual Community Benefits Report. Wisconsin hospitals provide over \$1.4 billion in community benefits; nearly twice that if you include Medicare shortfalls and bad debt. This month's story is from the Langlade Hospital in Antigo:

"Mary and Jim wondered what they would do. How would they ever be able to pay for their continuing medical needs?"

"Mary was living in constant pain and was in need of a total knee replacement. Jim was battling aggressive cancer, undergoing chemotherapy, had been hospitalized for several days and was feeling weak, fragile and very sick."

"The couple was further distraught by the financial stress since they were living on Social Security. Not

the golden years that they had hoped for."

"After meeting with Langlade Hospital Financial Services staff member, Gail, their days looked brighter. Gail assisted them with completing the Community Care application and after thorough review was happy to be able to tell them not to worry. 'The hospital made sure that I got my new knee, and that Jim got his chemotherapy. They are still providing Jim with excellent cancer care,' said Mary. 'I don't have to worry that we will lose our house.'"

"Jim continues his battle with cancer and is in and out of the hospital. Mary stops in to see Gail and shares how very appreciative they are for the help that they have been given by Langlade Hospital. Gail can see the toll that her husband's illness has taken

on Mary, in addition to her own medical concerns. 'It feels good to be able to help relieve some of their burden,' said Gail."

"Mary and Jim's balances after their insurance made payment are covered at 100 percent through the Langlade Hospital Community Care Program."

<p>National Rural Health Association Annual Policy Institute—January 25-27th Capital Hilton, 1001 16th Street NW, Washington, DC Register online at: www.nrharural.org</p>

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