As health systems consolidate across the country, small rural hospitals are being left behind — and disappearing.

According to a March 2016 report to Congress by the Medicare Payment Advisory Commission, 50 percent of hospitals that closed in 2014 were in urban areas and 50 percent were in rural counties. Yet all of the hospitals that opened in that same year were in cities. Most of the small, rural hospitals that closed were the only providers of inpatient care in their communities.

These hospitals tend to serve the people targeted by population health strategies: elderly and uninsured residents with high rates chronic illness and unemployment. Rural hospitals don’t just play a vital role in healthcare reform, they also provide essential emergency and primary care to those vulnerable demographics. Compounding the problem, they are often the largest employer in town.

So when a rural hospital shuts its doors, the effects are pervasive, says George Pink, Ph.D., Deputy Director of the Rural Health Research Program at the University of North Carolina.

“You’re closing a community’s primary source of healthcare and probably source for occupation,” Pink says. “When rural areas don’t have a hospital, it is harder for them to attract businesses, and companies leave. The perception of a disintegrating healthcare system reduces all providers’ desire to stay in the community. So services you wouldn’t expect to be affected — a breastfeeding clinic, a diabetes clinic, an obesity clinic — also leave. The result is a shrinking community.”
What’s making it so hard for rural hospitals to keep their doors open? Pink cites declining populations and a reduction in inpatient business, which is traditionally more profitable than outpatient care. Over the last eight years, he notes, the average occupancy rate in hospitals with fewer than 100 beds has declined by almost 23 percent, while the occupancy rate at urban hospitals has dropped by just four percent.

The double whammy of federal requirements and the 2008-2009 economic downturn also set rural hospitals on a downward spiral, Pink says. “A lot can’t afford EHR technology” to comply with Meaningful Use requirements, he says, and “after the recession, they were frozen out of the capital market. Their buildings deteriorated and patients said, ‘we’re going to the newer hospital in the city.’”

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Most rural hospitals that have closed since 2010 were located in states, primarily in the South, that did not expand Medicaid coverage. Some believe that, in non-expansion states, a dearth of patients is causing hospitals to go bankrupt. Others contend that, in expansion states, newly insured patients — struggling to pay high deductibles — have sent bad debt skyrocketing in rural hospitals.

And some say the challenges to rural hospitals far exceed the effects of Medicaid.

“Rural hospitals in the South have been much more unprofitable than those in other parts of the country for a long, long time,” Pink says. His research indicates, however, that “lack of Medicaid expansion is resulting in higher rates of financial distress.”

Here and there, however, a few rural hospitals are telling a different story. They’re assessing their communities’ needs, reducing inpatient capacity and expanding ambulatory care. They’re expanding the roles of community health workers — training EMTs to do primary care, for example — and joining rural ACO networks. They’re adopting telemedicine and other low-cost technologies to enhance care delivery. And new cost-effective models of healthcare for rural America are creeping through Congress.

Whatever the future holds, the bond between rural hospitals and their communities remains strong. “Patients might travel into the city for procedures they feel are major,” says Pink, “but when it comes to their hospital being threatened, it’s part of their community and they take pride in their hospital.”

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(Photo credit: Taylor Sisk; Yadkin Valley Community Hospital, Yadkinville, NC)