Chapter 4

The State Role in Rural Health

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The State Role in Rural Health

INTRODUCTION

Faced with dwindling Federal resources, States have assumed more responsibility for defining and addressing their health care needs. The potential role for States in improving rural health services is large and diverse (table 4-l). To carry out this role, several States have created State offices of rural health, and many have developed specific legislative and administrative initiatives. In some States, sweeping changes in rural health care policy and delivery have developed quickly. In others, policymakers and planners are only just beginning to address rural health issues.

This chapter presents an overview of State rural health activities, discusses these activities, and profiles selected recent State rural health legislative initiatives.[1]

OVERVIEW OF STATE RURAL HEALTH ACTIVITIES: RESULTS OF AN OTA SURVEY

OTA conducted a survey of States in fall 1988 to identify: 1) those rural health issues States perceive to be most critical, and 2) specific activities and programs that States had undertaken during the past 3 years to address these issues. The survey targeted organizations that were either State-based or State-supported and that were involved in rural health planning, development, research, or policy. All 50 States responded to the survey.

The survey defined a State activity as any activity in which the State was involved directly (through regular paid staff time or State budget authority) or indirectly (e.g., through contract to an outside

Table 4-l—Potential State Roles for Improving Rural Health Services

Developing rural health policy
- Establish special office, task fore e, or commis – sion
- Conduct special studies

Providing technical assistance and information to rural providers and community groups
- Provide technical assistance to promote regionalization and integration of services
- Provide information to providers and community groups

Assessing and changing State laws and regulations
- Assess impact of regulatory requirements for small and rural hospitals
- Change State licensure laws and regulations to promote greater flexibility in the staffing and configuration of rural medical facilities
- Change certificate-of-need requirements or create special exemptions for rural medical facilities
- Change State scope-of-practice laws to permit greater use of midlevel practitioners in rural areas
- Create more flexibility in the definition of **"continuous service" for emergency medical facilities**

Maintaining needed services
- **Establish criteria for designating "essential" rural providers or for intervening in possible closure of rural hospital**
- Provide grant funds to promote linkages between facilities and to stimulate the development of new models and approaches
- Create special capital equipment funds to assist hospitals needing access to low-interest capital loans

Increasing the availability of health professionals
- Establish scholarship programs for rural providers
- Fund rural preceptorship programs
- Permit and encourage the cross-training and multiple certification of allied health professionals

Increasing payment or financing
- **Expand Medicaid eligibility for the poor**
- Increase Medicaid reimbursement to reflect "true costs" of providing services in rural areas
- Stimulate private sector funding through subsidies for health insurance for low-income rural workers
- Change reimbursement to provide more incentives for providers practicing in rural areas
- Increase reimbursement to rural clinics providing Medicaid-covered ambulatory services
- Increase reimbursement for rural emergency medical services and transportation services

SOURCE: D. Helms, "The Role of the State in Improving Rural Health Care," paper presented at a rural health care workshop sponsored by the National Center for Health Services Research, Rockville, MD. Nov. 29. 1988.

[1]Other State rural health activities are discussed in chs. 7,8, 11, 13, and 15 of this report.

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Table 4-2—List of Respondents to OTA's 1988 Survey of State Rural Health Activities

State	Number of respondents	Entities whose activities were reported[a]
Alabama	1	* **Department of Public Health**
Alaska	1	* **Division of Public Health**, Department of Health and Social Services
Arizona	1	* **Rural Health Office**, University of Arizona
Arkansas	2	* **Section of Health Facilities, Services & Systems**, Department of Health * **Arkansas Area Health Education Centers Program**
California	2	* **Office of State Health Planning & Development** * **Rural and Community Health Division**, Department of Health Services
Colorado	1	* **Department of Health**
Connecticut	1	* **State of Connecticut**
Delaware	1	* **Division of Public Health**, Department of Health and Social Services
Florida	1	* **State of Florida**
Georgia	2	* **Center for Rural Health**, Georgia Southern College * **Primary Health Care Section**, Division of Public Health, Department of Human Resources
Hawaii	1	* **Department of Health**
Idaho	1	* **State of Idaho**
Illinois	1	* **State of Illinois**
Indiana	1	* **State of Indiana**
Iowa	1	* **State of Iowa**
Kansas	1	* **State of Kansas**
Kentucky	1	* **State of Kentucky**
Louisiana	1	* **State of Louisiana**
Maine	1	* **State of Maine**
Maryland	2	* **Primary Care Cooperative Agreement Unit**, Department of Health and Mental Hygiene * **Maryland Health Resource Planning Commission**
Massachusetts	1	* **Department of Public Health**
Michigan	1	* **Division of Health Facility Planning & Policy Development**, Bureau of Health Facilities, Department of Public Health
Minnesota	1	* **Department of Health**
Mississippi	1	* **Office of Primary Care Liaison**, Department of Health
Missouri	2	* **Bureau of Primary Care**, Division of Local Health & Institutional Services, Department of Health * **Certificate of Need Program**, Department of Health
Montana	1	* **Bureau of Health Planning**, Department of Health & Environmental Sciences
Nebraska	1	* **State of Nebraska**
Nevada	2	* **Nevada Office of Rural Health**, University of Nevada * **Division of Health**, Department of Human Resources
New Hampshire	1	* **Division of Public Health Services**, Department of Health and Human Services
New Jersey	1	* **State of New Jersey**
New Mexico	2	* **Primary Care Section**, Public Health Division, Department of Health and Environment * **New Mexico Health Resources**
New York	1	* **State of New York**
North Carolina	2	* **Office of Health Resources Development**, Division of Facility Services, Department of Human Resources * **North Carolina Area Health Education Centers Program**
North Dakota	2	* **Department of Health** * **Center for Rural Health Services, Policy & Research**, University of North Dakota
Ohio	1	* **Primary Care Section**, Office of Health Resources, Department of Health
Oklahoma	3	* **Oklahoma Health Planning Commission** * **Oklahoma Physician Manpower Training Commission** * **Department of Health**
Oregon	1	* **State of Oregon**
Pennsylvania	2	* **Division of Hospitals**, Department of Health * **Bureau of Health Financing & Program Development**, Department of Health
Rhode Island	1	* **State of Rhode Island**
South Carolina	1	* **Office of Primary Care**, Department of Health and Environmental Control
South Dakota	2	* **Department of Health** * **Rural Health Program**, University of South Dakota School of Medicine

Table 4-2—List of Respondents to OTA's 1988 Survey of State Rural Health Activities-Continued

State	Number of respondents	Entities whose activities were reported[a]
Tennessee	1	* **State of Tennessee**
Texas	3	* **Department of Health**
		* **Department of Agriculture**
		* **Texas Higher Education Coordinating Board**
Utah	1	* **State of Utah**
Vermont	1	* **State of Vermont**
Virginia	1	* **State of Virginia**
Washington	1	* **Department of Health**
West Virginia	1	* **Department of Health**
Wisconsin	1	* **State of Wisconsin**
Wyoming	1	* **Health Department**

[a]Boldface type indicates the entity for which the respondent reported activities. Normal type indicates the location of that entity within the State government or other organization.

SOURCE: Office of Technology Assessment, 1990.

organization). The survey asked central State health administrative officers in the targeted organizations about State activities in areas such as technical assistance, special rural health initiatives, personnel issues, and research. It did not explicitly attempt to obtain information about programs not formally linked to the State, although some respondents used open-ended questions to describe such programs. A description of the survey methods, a copy of the survey instrument, and a list of addresses of survey respondents are included in appendix D of the report.

General Description of Responding Organizations

Table 4-2 shows the entities whose activities are reflected in the survey.

Organizational Base and Authority

Of the 65 responding organizations in 50 States, 57 were State-based, 7 were university-based, and 1 was a private nonprofit organization created through Governor's action that later gained legislative authority. Most of the organizations (62 percent) had been established through State legislative authority, with a substantial minority (35 percent) established through administrative authority.

Funding

States inconsistently reported financial data,[2] but OTA was able to analyze State rural health activity funding sources for 1989 for 42 States and total rural health budget changes nom 1987 to 1989 for 33 States.[3] Although the majority of States reported modest increases in their total rural health budgets from 1987 to 1989, the budgets of nearly one-fourth of the States (8 of 33) had decreased (table 4-3). States' dependence on Federal, State, and other funding sources varied widely. The proportion of funding derived from Federal sources ranged from 0

Table 4-3-Changes in State Rural Health Budgets[a], 1987-89

Percent change in rural health budget[a], 1987-89	Number of States[b]
-41 or less	2
-21 through -40	3
-1 through -20	3
0 through +20	13
+21 through +40	4
+4 I or greater	8
Total number of States reporting	33

[a]Respondents were asked to provide figures reflecting their total budget for rural health activities for 1987, 1988, and 1989. Methods of budget calculation varied considerably. For multiple respondent States, budget figures for all respondents were totaled and the percent change was calculated from the total.

[b]Responses from only 33 States were used in this analysis because some States were unable to provide comparison data for 1987.

SOURCE: Office of Technology Assessment, 1990.

[2]See app. D.

[3]For States with more than one respondent, weighted percentages were determined if all respondents had provided financial data. If all respondents had not provided data, data from that State were regarded as missing.

Table 4-4-Funding Sources of Organizations Responding to OTA's Survey of State Rural Health Activities, 1989

	Mean percent of 1989 funding[a, b] derived from:		
	Federal sources	State sources	Other sources[c]
All States (42)[d]	44	42	12
Region:[e]			
Northeast (5)	51	35	15
South (15)	40	48	12
Midwest (12)	44	31	17
West (10)	47	49	5
"More rural" States (14)[f]	38	55	7
"Less rural" States (28)[f]	47	32	14
States with an ORH (11)[g]	47	42	11
States without an ORH (31)[g]	43	42	12

[a]Of the 42 States providing financial data, 41 provided 1989 budget estimates and 1 provided 1988 budget estimates. The 1988 budget estimate was averaged in with those for 1989.
[b]Means were calculated by averaging the individual percentages for each State within a given source category. This explains why the rows do not add up to 100.
[c]"Other" sources can include private funding, local funding, and fee-for-service revenues.
[d]Numbers in parentheses denote number of States in each category for which financial information was available for this analysis.
[e]See app. F for a list of States in each region.
[f]States were classified as "more rural" or "less rural" depending on the percentage of their population residing in nonmetro areas in 1986 ("more rural" = over 50 percent; "less rural" = 0-50 percent. (See app. D for a list of States.)
[g]An "office of rural health" (ORH) was either identified as such by a respondent or was known to be an office whose primary responsibility was to administer to the health needs of rural areas of the State. (See app. D for a list of ORH States and an explanation of how these States were identified.)

SOURCE: Office of Technology Assessment, 1990.

percent in one State to 100 percent in 6 States. Eighteen States (42 percent) derived more than 50 percent of their funding from Federal sources. State funding likewise ranged from 0 percent in 8 States to 100 percent in 5 States. Twenty-five States (59 percent) received more than 50 percent of their funding from State sources.[4]

In general, ''more rural" States received a higher percentage of funding from State sources and a lower percentage of funding from Federal sources than did "less rural" States (table 4-4).[5] One explanation may be that "more rural" States are appropriating more State funds for rural health activities; alternatively, the Federal Government may be directing its rural health funding to "less rural" States. States with an office of rural health (ORH) had a higher percentage of funding from Federal sources than did States without an ORH.[6] A possible explanation is that ORH States have a more centralized focus for rural health efforts and have been more successful in obtaining Federal funding.

Mean proportions of State and Federal funding did not differ greatly among regions,[7] but States in the South and West reported somewhat greater dependence on State funding sources than did States in the Northeast and Midwest. States in the West reported much lower dependence on "other" funding sources (e.g., local and private funding and revenues).

Conversations with several respondents revealed that, in a number of States, the major source of funding was a Primary Care Cooperative Agreement with the U.S. Department of Health and Human Services (see ch. 3). Other Federal funding sources

[4]The proportion of funding from sources other than Federal and State governmentranged from 0 percent in 25 States to over 70 percent in 3 States.

[5]States were classified as ''more rural'' or ''less rural'' depending on the *proportion* of their population residing in nonmetro areas in 1986 (''more rural'' = over 50 percent; ''less rural" = 0 to 50 percent). (See app. D for a list of States.) Seventy-nine percent of the ''more rural'' States providing financial data received more than 30 percent of their funding from State sources, compared with 48 percent of ''less rural'' States.

[6]An ''office of rural health'' was either identified as such by a respondent or was known to be an office whose primary responsibility was to administer to the health needs of rural areas of the State. (See app. D for a list of ORH States and an explanation of how these States were identified.) Eighty-two percent of ORH States received more than 30 percent of their funding from State sources, compared with 50 percent of non-ORH States.

[7]States were divided into four standard regions: Northeast, South, Midwest, and West. (See app. F for the States included in each region.)

Table 4-5-Overall Activity Strength[a] of States Responding to OTA's Survey of State Rural Health Activities[b]

	"Less active" (0-15 activities)	'*Active" (16-30 activities)	"More active" (31-54 activities)
U.S. total [50][c]	11 (22%)[d]	18 (36%)	21 (42%)
Within regions:			
Northeast [9]	3 (33%)	5 (56%)	1 (11%)
South [16]	3 (19%)	3 (19%)	10 (63%)
Midwest [12]	3 (25%)	5 (42%)	4 (33%)
West [13]	2 (15%)	5 (38%)	6 (46%)
"More rural" States [15]	3 (20%)	6 (40%)	6 (40%)
"Less rural" States [35]	8 (23%)	12 (34%)	15 (43%)
States with ORH [12]	0 (o%)	5 (42%)	7 (58%)
States without ORH [38]	11 (29%)	13 (34%)	14 (37%)

[a]Activity strength measures only number of reported activities, not level of effort expended in these activities.
[b]Respondents reported activities they had been directly involved in at any time during the past 3 years. The end date of this period was late 1988 or early 1989, depending on the State.
[c]Numbers in brackets denote number of States in each category for which data were analyzed.
[d]Numbers in parentheses indicate the percentage of States within that region or category that were "less active," "active," or "more active."

SOURCE: Office of Technology Assessment, 1990.

included block grant funding to State health departments, special research or program grants, and Federal funding to health professions schools.

Rural Health Objectives

Organizational objectives cited by respondents ranged from the very broad (e.g., providing information to increase awareness of rural health issues) to the very specific (e.g. providing mobile dental health services). Some of the more frequently mentioned objectives concerned:

- improving access to primary health care services, either throughout the State (13 States) or specifically in rural areas (12 States);
- provider recruitment and retention (22 States);
- rural health care systems development and network coordination (21 States);
- technical assistance to health care providers and communities (12 States);
- needs of underserved and at-risk populations (11 States);
- resource identification and procurement (7 States);
- support of emergency medical services activities such as planning, training, and technical assistance (estates); and
- development of rural health policy, plans, and standards (estates).

Rural Health Activities

Specific Activities

The survey asked whether responding organizations had been directly involved during the past 3 years in specific rural health activities within the following categories:[8]

- provider recruitment and placement;
- financial assistance to local organizations;
- technical assistance to rural communities, health facilities, and health providers;
- rural health research;
- rural health systems coordination and implementation;
- education;
- legislative affairs relating to rural health; and
- rural health-related publications.

The survey form suggested 54 specific activities within these categories; on the average, respondents identified 25.5 that were conducted in their State. Total number of activities ranged from l to 44. The number of activities reported tended to be greater in the South and West than in the Northeast and Midwest (table 4-5). No notable differences were found between "less rural" and "more rural" States; however, States with ORHs tended to engage in more activities than did other States.

[8]As noted in app. D, the survey did not attempt to determine the level of effort respondents or their agencies were devoting to any given activity.

Table 4-6--State Provider Recruitment and Placement Activity[a]

	Number of States that recruited providers			Range of number of placements in States that placed at least one provider	Number of States that did not recruit
	Total	Recruited & placed	Recruited but did not place[b]		
Physician (MD/DO)[c]	35	33	2	1 - 602	14
Registered nurse	16	11	5	1 - 520	33
Nurse practitioner	19	7	12	1 - 10	31
Physician assistant	17	7	10	1 - 12	33
Mental health professional	15	8	7	2 - 17	35
Dentist	8	8	0	1 - 8	42
Pharmacist	3	3	0	1 - 27	47
Physical therapist	4	4	0	1 - 12	46
Paramedic	1	1	0	19 - 19	49
Other providers[d]	10	10	0	1 - 194	40

[a]States were asked t. report the number of providers recruited and placed during the Past 3 Years. The end date of this period was late 1988 or early 1989, depending on the State. Numbers reflect only recruitment and placement activity carried on by the responding State organizations, which may only be a small proportion of all such activity in the State.

[b]This indicates the number of States that recruited a particular type of provider but did not place any during the past 3 years. For example, if a State recruited 9 physicians and only placed 3, it would not be counted in this column but rather in the second column of this table. In this sense, it is an underestimation of the number of States that had difficulty filling all of the positions for which they were actively recruiting.

[c]Data not available for one State.

[d]other providers recruited include: nutritionists, licensed practical nurses, occupational therapists, speech therapists, dental hygienists.

SOURCE: Office of Technology Assessment, 1990.

Provider Recruitment and Placement—Thirty- eight of the 50 States (76 percent) reported that they had engaged in provider recruitment and placement activities.[9] Of these, more reported recruitment and placement of physicians than of other health professionals (table 4-6). The number of providers placed varied widely. One State had placed only a single physician during the past 3 years, while another had placed 602. A considerable number of States reported unsuccessful attempts to recruit nurse practitioners and physician assistants. States most frequently recruited through the National Health Service Corps (NHSC), service-contingent State scholarships, State loan forgiveness/repayment programs, and placement services (figure 4-l). Nine States reported using other types of financial incentives (e.g. recruitment travel assistance) to attract and place health personnel.

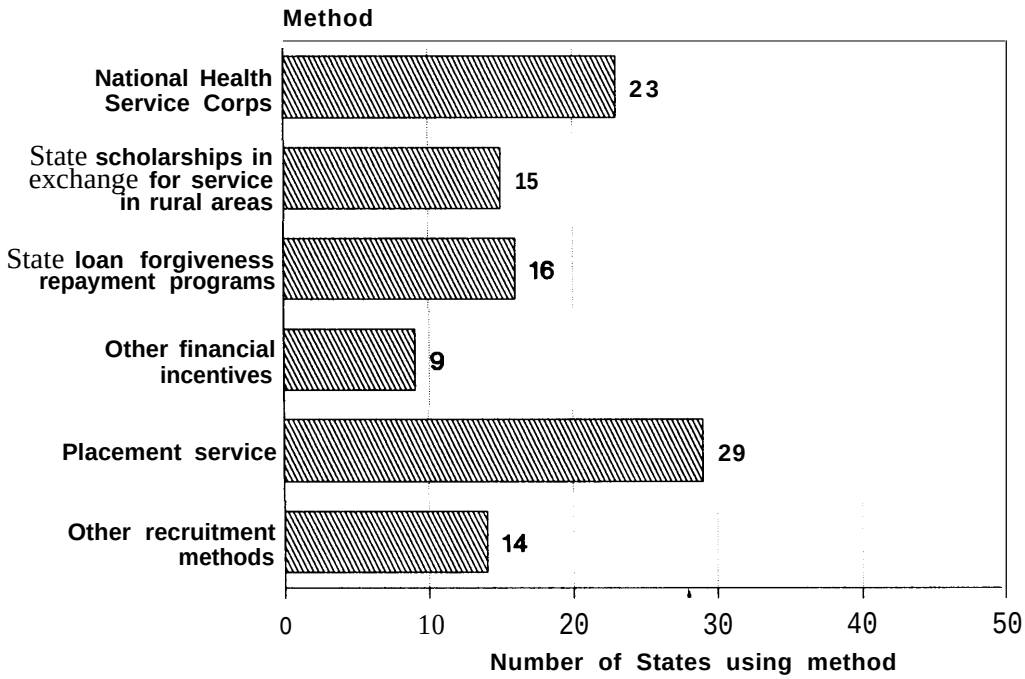
Regional comparisons showed the South to be particularly active in provider recruitment and placement. More States in the South (63 percent) were likely to use the NHSC as a recruitment source than were States in the Northeast (22 percent), West (50 percent), and Midwest (42 percent).[10] Southern States were also more than twice as likely as States in other regions to recruit through State loan forgiveness/repayment and scholarship programs. Other recruitment methods used by States included:

- a program that provided travel allowances to prospective physicians for visits to practice sites (North Carolina),
- a bonus of $20,000 to any physician willing to locate in a designated shortage area (Oklahoma),
- a loan fund to help physicians and communities establish rural primary care clinics (Arkansas),
- a program to provide equipment and startup funds for physicians locating in areas eligible for the State's loan forgiveness program (New York),
- establishment of rural placement offices in State medical schools (Oklahoma),
- a tuition reimbursement program for physicians locating in communities of 2,500 or fewer

[9]These numbers reflect only recruitment and placement activity carried on by the responding State organizations, which may only be a small percentage of all such activity intestate.

[10]This may be a reflection of the relatively high concentration of potentially qualifying NHSC placement sites in the South compared with other regions (see ch. 11).

Figure 4-I-State Use of Provider Recruitment and Placement Methods[a]



[a]States were asked to report methods used to recruit personnel during the past 3 years. The end date of this period was late 1988 or early 1989, depending on the State.

SOURCE: Office of Technology Assessment, 1990.

residents (South Dakota),
- payment of malpractice insurance premiums for obstetricians (Tennessee),
- requirements that State medical residency programs actively recruit physicians to underserved areas (Texas),
- newsletters advertising available positions,
- low-interest loans in exchange for service in rural areas, and
- a ***locum tenens***[11] program for nurse practitioners and physician assistants.

In telephone conversations and in open-ended responses, some respondents indicated that reduction of the Federal NHSC program had had a negative impact on physician availability in undeserved rural communities.

Financial Assistance to Local Organizations--Thirty-five States *(70* percent) were offering some form of financial assistance to local organizations and individuals. Only 3 were providing loans to local organizations, while 9 were providing funds on a matching basis, and 31 were providing direct unmatched subsidies. Fifteen States were providing other types of financial assistance. States in the Northeast and South were more likely to have provided local financial assistance than were those in the Midwest and West. Some examples of State financial assistance include:

- provision of living allowances to nursing and medical students while they are in clinical training at rural practice sites (Arizona),
- loan fund to support the development of local services and improve access to services (Arkansas),
- a Mortgage Loan Insurance Program to help health facilities finance capital expenditures at reasonable cost (California),
- matching funds for local transport systems for newborn infants (Delaware),
- rural medical school demonstration projects (Florida), and
- funds for recruitment and retention of primary care providers in community health centers (Tennessee).

[11]This is a program that provides personnel to cover for practitioners during vacation, educational, or other leave periods.

Table 4-7—State Involvement in Rural Health Technical Assistance Activities[a]

Activity	States reporting involvement (N=50)
Technical assistance to rural communities:	
HMSA/MUA/MUP[b] designations	41 (82%)
Statewide rural health needs assessment	29 (58%)
Other needs assessments	34 (68%)
Community board training	24 (48%)
Grant application assistance	39 (78%)
Program planning	37 (74%)
Resource identification	45 (90%)
Other types of technical assistance	16 (32%)
Technical assistance to rural health facilities/providers:	
Facility development/construction consultation	26 (52%)
Grant application assistance	40 (80%)
Management assistance	31 (62%)
Other types of technical assistance	18 (36%)

[a]Respondents reported activities they had been directly involved in at any time during the Past 3 years. The end date of this period was late 1988 or early 1989, depending on the State.
[b]HMSA = Health Manpower Shortage Area; MUA = Medically Underserved Area; MUP = Medically Underserved Population. These are Federal designations used for the allocation of Federal health resources, and they require substantial involvement of State and local officials in the designation process (see ch. 11).
[c]Includes assessments of needs of particular areas, Population, and health facilities and services.

SOURCE: Office of Technology Assessment, 1990.

Technical Assistance—States were very active in providing technical assistance to rural communities, health facilities, and health providers (table 4-7). Out of 12 1isted on the survey, the mean number of technical assistance activities reported by States was 7.6. Only one State reported no involvement in such activities. The types of technical assistance most frequently provided by States were resource identification, Federal shortage area designation application assistance,[12] grant application assistance, and program planning assistance. Other technical assistance activities included:

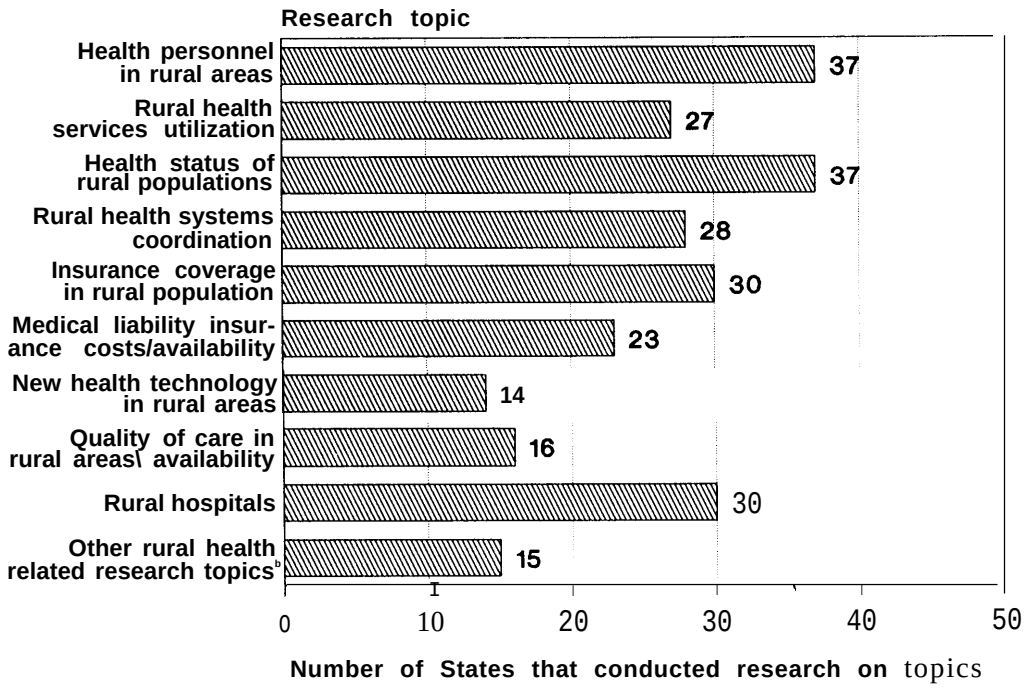
- accreditation workshops for rural health facilities,
- technical assistance to rural facilities for certificate-of-need (CON) and licensure application,
- physician recruitment assistance,
- health provider contract negotiation,
- rural socioeconomic assessments and rural survey assistance,
- assistance to small hospitals restructuring their service and governing structures,
- market research and education,
- analysis of trends in rural hospital utilization and financing, and
- expansion of Rural Health Clinic certification.

Research—Nearly three-fourths of all States reported that they had conducted research on the health status of rural populations or on rural health personnel. Over one-half had conducted research on rural health services utilization, rural health systems coordination, or insurance coverage in the rural population (figure 4-2).[13]

Rural Health Systems Coordination and Implementation--Most States had undertaken activities to promote the coordination of rural health services and facilities through the development of networks and systems of facilities and providers (figure 4-3).Only three States (6 percent) reported no such involvement. Participants in State-promoted health system "alliances"[14] included, but were not limited to: hospitals, primary care providers, health departments, mental health centers, health professions education institutions, State primary care associa-

[12]Federal shortage area designations include Health Manpower Shortage Areas and Medically Underserved Areas/Populations. See ch. 11 for discussion of Federal and State shortage area designations.
[13]Responses reflect research efforts on a variety of levels—primary and secondary, formal and informal.
[14]The term "alliance" was not defined in the questionnaire. It may include arrangements ranging from mergers to shared purchase or staffing arrangements to informal referral networks between medical and other human service providers in rural and urban areas.

Figure 4-2-State Involvement in Rural Health Research Activities[a]



[a]Respondents reported activities they had been directly involved in at anytime during the past 3 years. The end date of this period was late 1988 or early 1989, depending on the State.
[b]Other rural health-related topics included: border health utilization patterns (AZ); allied health personnel in rural hospitals (FL); emergency medical services (GA); perinatal care access (GA); family planning (GA); access to pharmacy services (GA); knowledge and practices in underserved populations regarding acquired immunodeficiency syndrome (GA); geriatric care (Hi); long-term care (MD); travel time between rural hospitals (MD); frontier health services (NM, SD); Federal and State-funded primary care-centers (TN); site-specific epidemiologic studies (TX); transportation systems in shortage areas (WA).
[c]Valid responses were received from all 50 States.

SOURCE: Office of Technology Assessment, 1990.

tions, nursing homes, laboratories, and pharmacies. Over one-half of States had promoted alliances between hospitals and other health providers, while nearly four-fifths of States had promoted alliances that involved only nonhospital providers.

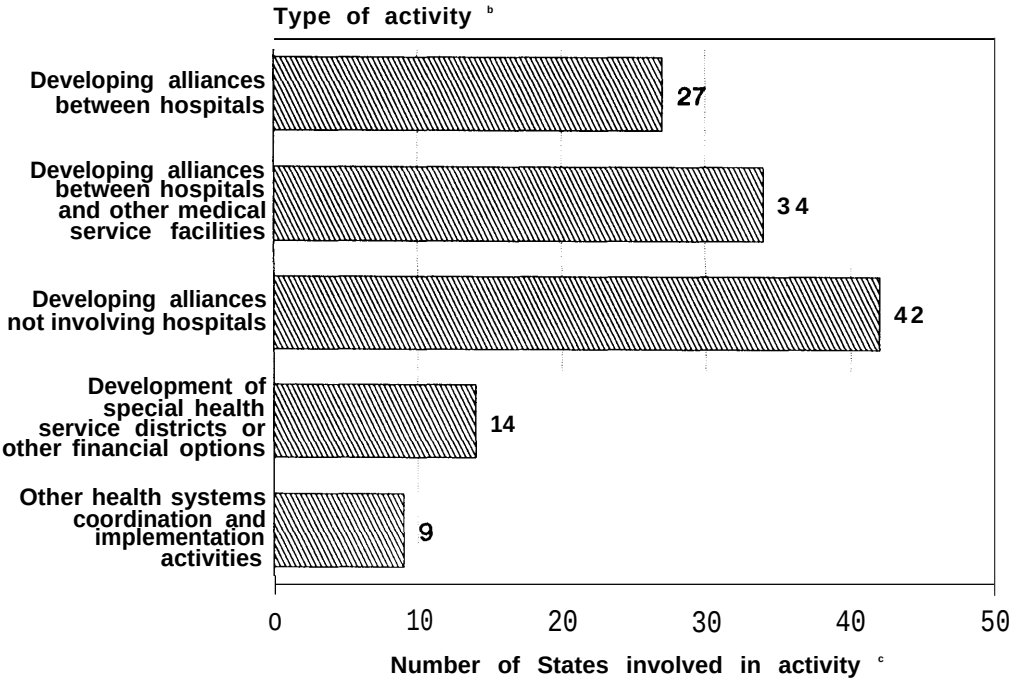
Nine States reported involvement in other types of rural health systems coordination and implementation activities, including:

- the development of adolescent health services and prehospital emergency medical services (Hawaii);
- the Iowa Rural Work Group, which provided a forum for discussion of a variety of rural concerns among representatives of Federal and State agencies;
- defining "rational service areas" for primary care to assist in State and local planning efforts (Nevada);
- development of multicounty health districts to help consolidate and integrate health resources in contiguous counties (Texas); and
- grant programs to encourage formation of alliances between health service facilities (New York).

Educational Activities-Forty-five States were conducting rural health-related educational activities, with five States reporting no such activities. Over two-thirds were involved in health professions education for rural providers, and well over one-half were involved in providing continuing education for rural health professionals. Over one-half had organized Statewide rural health conferences (figure 4-4).

Legislative Affairs--Forty-four States reported involvement in legislative affairs. Thirty-four had developed task forces or committees to address rural health issues. Thirty-nine of the responding organizations had worked with State legislatures and/or legislative committees on rural health issues. Six reported other types of involvement in legislative affairs related to rural health. States in the Northeast

Figure 4-3-Stated Involvement in Rural Health Systems Coordination and Implementation Activities[a]



[a]Respondents reported activities they had been directly involved in at any time during the past 3 years. The end date of this period was late 1988 or early 1989, depending on the State.
[b]The term "alliance" was not defined for respondents, and may include a variety of formal and informal arrangements.
[c]Valid responses were received from all 50 States.
SOURCE: Office of Technology Assessment, 1990.

were considerably less likely to report involvement in legislative affairs (56 percent) than were States in the South (100 percent), Midwest (92 percent), and West (92 percent).

Publications-Rural health-related publications had been produced by respondents in 40 States.[15] The most common were policy recommendations (21 States), newspaper articles (20), research reports (18), newsletters (18), and information packets (17). Other publications included annual reports and evaluation reports.

Priority Areas for Rural Health Activities-The survey asked respondents to choose three top priority areas from among the nine broader activity categories. As figure 4-5 shows, States most frequently ranked rural health systems coordination and implementation, provider recruitment/placement, and technical assistance as high priorities.

See table 4-8 for the distribution of selected rural health activities by State.

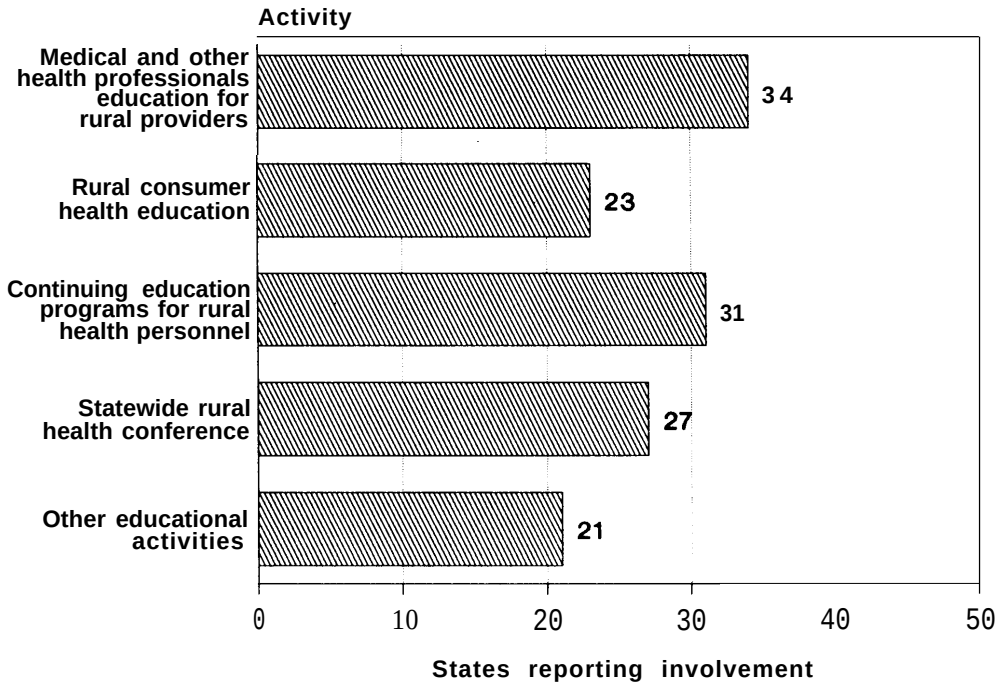
Comparative Characteristics of Active States

No notable differences in overall activity strength emerged between "more rural" and "less rural" States (see table 4-5). Concerning specific activity categories (table 4-9), ''more rural' States were slightly less likely to have engaged in NHSC recruitment activity, financial assistance to local organizations, and rural health systems coordination and implementation activities, but they were slightly more likely to indicate involvement in legislative affairs than were "less rural" States.

States with identifiable offices of rural health were more likely to be "active' or "very active" than were non-ORH States (see table 4-5). ORH States were slightly more likely to have engaged in general provider recruitment and placement activities, NHSC activity, and educational activities, and

[15]Nine States reported no publications, and one State did not provide information regarding publications.

Figure 4-4-State Involvement in Rural Health Educational Activities[a]



[a]Respondents reported activities they had been directly involved in at anytime during the past 3 years. The end date of this period was late 1988 or early 1989, depending on the State.
[b]Other rural health-related educational activities repot-ted by States include: statewide emergency medical services conferences; developing institutional alliances; local board training; management assistance workshops for rural providers; assistance in Area Health Education Center planning and liaison activities; and grant writing seminars.
[c]Valid responses were received from all 50 States.

SOURCE: Office of Technology Assessment, 1990.

they were much more likely to have conducted research activities or to have developed special task forces or committees to address rural health issues. ORH States were less likely, however, to have service-contingent State loan forgiveness/repayment or scholarship programs.

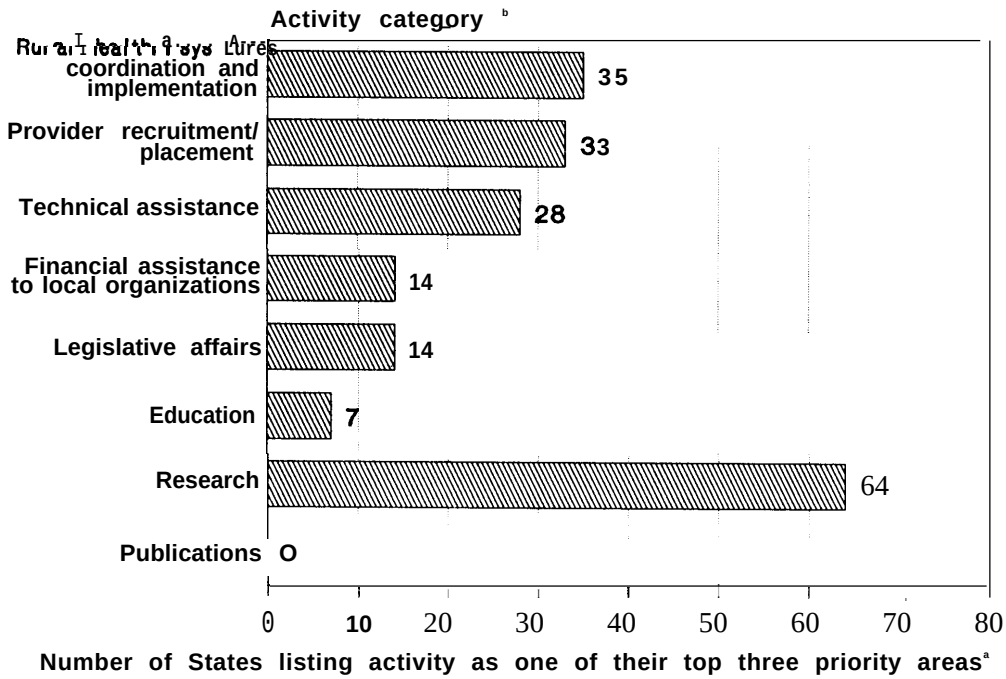
Ranking of Selected Rural Health Issues

OTA asked respondents to rank six general health care delivery issues for the extent to which they posed problems for rural areas (table 4-10). Health personnel problems were the most pervasive. They were more likely than any other issue to be ranked highly, regardless of region, degree of rurality, or presence of an ORH. Payment issues were also frequently ranked among the top three problems. Every issue was considered most important (ranked first) by at least one State. States in the Northeast and South more frequently ranked meeting the needs of special populations highly, while States in the Midwest and West more frequently stressed payment issues. Quality of care emerged as a major concern more frequently in the Northeast than in other regions, whereas Southern States were more likely to emphasize services issues.

While "less rural" States were much more likely to rank medical liability insurance costs/availability highly, "more rural" States were more likely to identify payment issues and meeting the needs of special populations as major problems. ORH States were more likely to stress medical liability insurance costs/availability and less likely to identify quality of care as a major problem than were non-ORH States.

States' activities were not consistently linked to their perceptions of key issues (table 4-11). In general, States that ranked a given issue among the top three were either slightly more likely than or equally as likely as other States to be involved in related activities. Activities that did not fit this pattern included use of NHSC as a recruitment method, State scholarship program, medical and other health professions education, continuing edu-

Figure 4-5-State Priorities for Rural Health Activities[a,b]



[a]For multiple respondent States, results are based on the response of a single respondent in each State identified as most knowledgeable about and central to State rural health activities. Data were missing for one State.
[b]These categories correspond to activity categories on the survey instrument. Some respondents may have answered this question based on their current priorities rather than on priorities that guided their activities during the previous 3 years.
SOURCE: Office of Technology Assessment, 1990.

cation for rural health professionals, and targeting of uninsured populations in rural health programs and activities. In these cases, States that had not ranked the related issue in the top three were *more* likely than other **States** to be involved in the activity.

Current and Future State Activities in Rural Health

The survey asked respondents to briefly describe three current activities or programs in their State that had been effective in addressing rural health issues.[16] Examples ranged from creating an ORH to providing services to rural people with acquired immunodeficiency syndrome (AIDS). Some of the more frequently cited effective activities included:

- Provider recruitment and retention activities (both educational and financial incentives),
- technical assistance activities,
- . Medicaid expansion or reform, and
- primary care systems and facility development.

Finally, the survey asked respondents to describe activities they would most like to see in their State to address rural health issues in the future. Among the wide variety of activities described, those most frequently mentioned included:

- improving the availability of primary care services in rural areas;
- creation of a State ORH;
- development of rural health policy, plans, and standards;
- facility planning and development;
- improvement of health insurance coverage;
- Medicaid expansion/reform;
- provider recruitment and placement (loan repayment/forgiveness program, scholarship program, development of rural-oriented curricula in health professional schools); and
- building stronger statewide rural health coalitions or consortia.

[16]Only one respondent indicated no current rural health activities.

Table 4-8-Selected State Rural Health Activities From **OTA's Survey of State Rural Health Activities**[a]

	Provider recruitment/retention				Technical assistance											
State	Loan forgiveness/ repayment programs	State scholarships in exchange for service in rural areas	Placement service	Financial assistance to local organizations	Needs assessments	Grant application assistance	Program planning	Management assistance	Resource identification	Facility development or construction consultation	Research	Systems coordination and implementation	Continuing education for providers	Statewide conference	Task force/committee to address issues	Work with legislatures/ legislative committees
Alabama		X		X	X	X	X	X	X	X	X	X	X	X	X	X
Alaska				X	X	X	X	X		X	X	X	X		X	X
Arizona			X	X	X	X	X	X	X		X	X	X	X	X	X
Arkansas	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
California	0	0	0	X	X	X	X	X	X	X	X	X			X	X
Colorado			X	O	X	X			X	X	X	X		X		X
Connecticut				X	X	X	X	X	X	X	X	X	X			*
Delaware	O	0	0	X		X					X	X				X
Florida	X		X	X	X	X	X	X	X		X	X	X		X	X
Georgia						X	X	X	X		X	X	X	X	X	X
Hawaii				X	X	X	X	X	X	X	X	X	X	X	X	X
Idaho		X			X	X	X	X	X		X	X	X		X	
Illinois	X	X					X		X	X	X	X			X	X
Indiana	X	X	X	X	X	X	X		X		X	X	X			X
Iowa	O	O	0	X	X	X	X		X		0	X		X	X	X
Kansas	O	O	0	X		X		X	X	X		X	X			X
Kentucky	X	X	X	X	X	X	X	X	X		X	X	X	X		X
Louisiana			X		X	X	X	X	X	X	X	X	X	X	X	
Maine	X		X	X	X	X	X		X	X	X	X	X	X	X	X
Maryland	X	X	X	X	X	X	X	X	X	X	X	X	X			X
Massachusetts				X	X	X	X	X	X		X	X	X		X	
Michigan				O		X	X	X	X			X		X	X	X
Minnesota	0	0	0	X	X	X	X		X		X	X	X	X	X	X
Mississippi			X		X		X		X		X	X	X			X
Missouri	X		X	X	X	X	X	X	X	X	X	X		X		X
Montana						X			X	X						X
Nebraska		X	X		X	X			X		X	X		X	X	X
Nevada			X	X	X	X	X	X	X		X	X	X		X	X
New Hampshire				X							X					
New Jersey	0	0	0	X	X				X	X	X	X	0	0	X	X
New Mexico	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
New York	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
North Carolina	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
North Dakota			X	X	X	X	X	X	X	X	X	X	X	X		X
Ohio			X	O		X	X	X	X			X				
Oklahoma	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
Oregon			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pennsylvania			X	X	X							X		X		
Rhode Island			X	O		X			X		X	X				
South Carolina		X	X	X		X			X			X	X		X	
South Dakota				0	X	X	X	X	X	X	X	X	X	X	X	X
Tennessee	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Texas	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Utah			X		X	X	X	X	X	X	X	X	X		X	X
Vermont	0	0	0	X	X		X		X		X	X	X		X	
Virginia		X		X	X	X			X		X	X	X		X	X
Washington	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X			X		X	X	X	X	X	X
Wisconsin			X		X	X	X	X	X		X	X		X	X	X
Wyoming	0	0	0								0	O			O	0

X = Responding organizations from the State indicated that they had been directly involved in this particular activity during the past 3 years (approximate range of years: 198f3through 1988).

O= Responding organizations indicated that, although they had not been directly involved in this activity during the past 3 years, other organizations in the State may have been involved.

• = Noted in reviewer's comments-doss not reflect original survey response.

[a]See table 4-2 for a list of the organizational entities whose activities were reported in this survey. See app. D for a copy of the survey instrument. Respondents reported activities they had been directly involved in at any time during the past 3 years. The end date of this period was iate 1988 or early 1989, depending on the State.

SOURCE: Office of Technology Assessment, 1990.

Table 4-9-Selected Rural Health Activities: Comparison of "More Rural" and "Less Rural" States and States With and Without Identifiable Offices of Rural Health (ORHs)

	Percent of States involved in activity:			
	"more rural"[a] (N=15)	"less rural"[a] (N=35)	ORH[b] (N=12)	non-ORH[b] (N=38)
Provider recruitment/placement	**73.3**	**77.1**	**91.7**	**71.1**
National Health Service Corps	40.0	48.6	58.3	42.1
State loan forgiveness/repayment program	33.3	31.4	25.0	34.2
Service-contingent State scholarships	33.3	28.6	16.7	34.2
Financial assistance to local organizations	**60.0**	**74.3**	**75.0**	**68.4**
Technical assistance	100.0	97.1	100.0	97.4
Research	**80.0**	**85.7**	100.0	**78.9**
Research on health personnel	73.3	73.5	91.7	68.4
Rural health Systems coordination and implementation	**86.7**	**97.1**	**100.0**	**92.1**
Education	**86.7**	**91.4**	**100.0**	**86.8**
Legislative affairs	**93.3**	**85.7**	**91.7**	**86.8**
Development of task force/committee to address rural health issues	**68.7**	**67.6**	**83.3**	**63.2**

[a]States were classified as "more rural" or "less rural" depending on the percentage of their population residing in nonmetro areas in 1986 ("more rural" = over 50 percent; "less rural" = 0-50 percent. (See app. D for a list of States.)

[b]An "office of rural health" was either identified as such by a respondent or was known to be an office whose primary responsibility was to administer to the health needs of rural areas of the State. (See app. D for a list of ORH States and an explanation of how these States were identified.)

SOURCE: Office of Technology Assessment, 1990,

A CLOSER LOOK AT STATE RURAL HEALTH ACTIVITIES

State Offices of Rural Health

A number of States have attempted to give their rural health efforts a more central focus by creating a formal ORH to coordinate, advocate, plan, administrate, and evaluate various rural health activities at the State level. ORHs maybe located within the State government, within a separate State-funded organization (e.g., a university), or in an organization that is entirely independent of the State government. In OTA's survey, most "ORH States" have State-based ORHs.[17] The survey found "OHR States'' to be more active than others in rural health activities. There are several possible explanations for this finding. First, the existence of a centralized entity whose primary purpose is to address rural health care issues may enhance the State's level of effort. Second, States that place a higher priority on rural health issues may be more active and more likely to have established a State ORH. Third, States with ORHs may have been in abetter position than other States to respond to questions regarding specific rural health activities and problems in the survey. ORH States reported larger proportions of State funding (table 4-3), suggesting that more targeted State funding is available in States that have taken steps to centralize efforts.

The 19 ORHs identified by OTA in 1990, based both on OTA's survey and on a survey conducted in 1988 by the National Rural Health Association (NRHA) (426), were located in State agencies, universities, Area Health Education Centers (AHECs), and other organizations (table 4-12).[18] At least six offices had been established since 1986, and an additional six States were interested in or planning to establish ORHs. The range and extent of ORH functions varies greatly and may include health personnel recruitment and retention, health personnel and consumer education, technical assistance and consultation, research and evaluation, informa-

[17]See app. D for thedefitionof''offlce ofrural health'' used in the survey.

[18]The number of ORHs in table 4-12 differs from the number identified in OTA's 1988 Survey of State Rural Health Activities because not all 19 ORHs were in existence in 1988 andsome were not identified as appropriate respondents.

Table 4-10-State Ranking of Six Major Rural Health Care Delivery Issues, 1989[a]

Issue	Number of States[bc] giving the issue a ranking of: (1)	(2)	(3)	(4)	(5)	(6)	(7)
A. Health provider issues (e.g., shortages, recruitment/retention)	22	13	10	4	1	0	0
B. Meeting the needs of special populations	10	10	8	14	5	3	0
C. Payment issues (e.g., Medicare, insurance coverage of rural populations)	10	14	7	13	6	0	0
D. Medical liability insurance costs/ availability	4	7	6	5	9	18	1
E. Services issues (e.g., hospital closures/ restructuring, systems planning and development)	3	5	15	5	14	8	0
F. Quality of care	2	1	5	9	13	20	0
G. Other issues[d]	0	0	0	0	0	1	2

	Number and percent of all States ranking issue among the top 3: (A)		(B)		(C)		(D)		(E)		(F)	
U.S. total [50][e]	45	(90%)	28	(56%)	31	(62%)	17	(34%)	23	(46%)	8	(15%)
Northeast [9]	9	(loo%)	6	(67%)	3	(33%)	2	(22%)	4	(44%)	3	(33%)
South [16]	12	(75%)	11	(69%)	9	(56%)	5	(31%)	9	(56%)	2	(13%)
Midwest [121	11	(92%)	5	(42%)	9	(75%)	5	(42%)	5	(42%)	1	(8%)
West [13]	13	(100%)	6	(46%)	10	(77%)	5	(38%)	5	(38%)	2	(15%)
"More rural" States [15][f]	13	(87%)	10	(67%)	12	(80%)	2	(13%)	6	(40%)	2	(13%)
"Less rural" States [35][f]	32	(91%)	18	(51%)	19	(54%)	15	(43%)	17	(49%)	6	(17%)
States w/ an ORH [12][g]	11	(92%)	7	(58%)	8	(67%)	6	(50%)	5	(42%)	1	(8%)
States w/o an ORH [38][g]	34	(90%)	21	(55%)	23	(61%)	11	(29%)	18	(47%)	7	(18%)

[a]Data of ranking may be late 1988 or early 1989, depending on the State.
[b]Valid responses were received from all 50 States.
[c]For multiple respondent States, results are based on the response of a single respondent in each State who was identified as most knowledgeable about and central to State rural health activities.
[d]A blank line was provided on which respondents could list an additional "general issue" and incorporate it into the ranking scale accordingly. The three "other" issues listed by respondents were: alternative delivery models; availability of obstetrics services; unspecified.
[e]Numbers in brackets denote number of States within each region or category.
[f]States were classified as "more rural" or "less rural" depending on the percentage of their population residing in nonmetro areas in 1986 ("more rural" over 50 percent; "less rural" 0-50 Percent. (See app. D for a list of States.)
[g]An "office of rural health" (ORH) was either identified as such by a respondent or was known to be an office whose primary responsibility was to administer to the health needs of rural areas of the State. **(See app. D for a list of ORH States and an explanation of how these States were identified.)**

SOURCE: Office of Technology Assessment, 1990.

tion dissemination, advocacy, health systems development and integration, and direct service (426).

State ORHs may also be of value in coordinating and implementing Federal rural health initiatives. In the 1988 NRHA survey of State ORHs, respondents saw the Federal Office of Rural Health Policy as playing a central role in dissemination of information regarding funding sources for rural health programs and activities, while State ORHs were seen as playing a critical role in determining State and regional rural health needs and guiding a more rational allocation and coordination of resources at these levels. Respondents also felt that the Federal office could assist in the development of new State ORHs by helping State governments identify potential resources and other State models. Examples of two States that have recently created ORHs are presented in box 4-A.

Selected Examples of State Legislative and Administrative Activity

The creation of special task forces or committees is a common step towards a comprehensive examination of State rural health issues. Thirty-four States

Table 4-1 —Relationship Between States' Perception of Major Rural Health Issues and Specific Rural Health Activities

Issue	Ranked issue 1-3 (number of States) Yes	No	Related activity	States ranking issue 1-3 and involved in the activity Number	Percent[a]	States NOT ranking issue 1-3 and involved in the activity Number	Percent[b]
Provider issues	<5	5	Had actively placed providers during past 3 years	34	(75%)	4	(80%)
			Had used NHSC as a recruitment method	20	(44%)	3	(60%)
			State loan forgiveness/repayment program	15	(33%)	1	(20%)
			State scholarship program	13	(28%)	2	(40%)
			Placement service	26	(57%)	3	(60%)
			Research on health personnel in rural areas	33	(73%)	4	(80%)
			Medical and other health professions education	29	(64%)	5	100%)
			Continuing education for rural health professionals	27	(60%)	4	(80%)
Medical liability insurance costs/ availability	17	33	Rural health-related research on medical liability insurance costs/availability	9	53%	1=	42%
Meeting the needs of special populations	28	22	Had targeted some of their rural health activities to special populations	26	93%)	20	(91%)
			Research on health status of rural populations	20	(71%)	17	(77%)
Payment issues	31	19	Research on insurance coverage in rural populations	20	(64%)	10	(53%)
			Research on rural hospitals	20	(64%)	10	(53%)
			Development of health service districts or other financial options	10	(32%)	5	(26%
			Had targeted uninsured populations in some of their rural health activities	22	(70%)	16	(84%)
			×ad targeted low-income populations in some of their rural health activities	27	(87%)	16	(84%)
Quality of care	8	42	Research on quality of care in rural areas/facilities	4	(50%)	12	(29%)
			Research on new technology in rural areas	3	(38%)	11	(26%)
Services issues	23	27	Had provided some form of technical assistance to rural communities	23	1∞%	26	·96%
			Had provided some form of technical assistance to rural health facilities/providers	22	(96%	21	(78%)
			Rural health systems coordination/implementation activities	22	(96%)	25	(93%)
			Research on rural health services utilization	14	(61%)	13	(48%)
			Research on health systems coordination	15	(65%)	13	(48%)
			Research on rural hospitals	18	(78%)	12	(44%)

[a]Percentage of States who ranked the related issue 1-3 and were involved in the activity.
[b]Percentage of States who did not rank the issue 1-3 and were involved in the activity.

SOURCE: Office of Technology Assessment, 1990.

Table 4-12-States With Offices of Rural Health, 1990

States with Offices of Rural Health:

State	Location of ORH
Arizona	University
Arkansas	State agency
California	State agency
Connecticut[b]	State agency
Georgia[c]	State agency & university
Illinois[c]	State agency
Iowa[a]	State agency
Kansas[c]	State agency
Nebraska[a]	Skate agency
Nevada	University
New Mexico	Not-for-profit organization
North Carolina	State agency
North Dakota	University
Oregon	State agency
South Dakota[c]	State agency & university
Texas	University
Utah	State agency
Washington	Area Health Education Center
Wisconsin	University

States interested in or planning to establish Offices of Rural Health:

Alabama	**Minnesota**
Alaska	**Mississippi[d]**
Michigan	**Montana**

[a]Established since 1986.

[b]Office of rural and urban health.

[c]Established since 1988.

[d]A 1990 bill (S.B.2398) **pending in the Mississippi State Legislature would create an office of rural health within the State Department of Health. There is an existing Rural Health Research Program in the University of Mississippi School of Pharmaceutical Sciences, but it is not involved in rural health policy or planning.**

SOURCE: Office of Technology Assessment, 1990. Based on data from National Rural Health Association, **"Report of the Task Force on Offices of Rural Health and State Rural Health Associations, National Rural Health Association, Kansas City, MO, Aug. 12, 1988, as updated by OTA.**

Box 4-A—Recently Created State Offices of Rural Health: Two Examples

Iowa—Created in 1989, the Iowa Office of Rural Health is located within the Department of Public Health (*302*). It is required by law to submit a report and recommendations to the State legislature on the impact of current Medicare reimbursement policy on rural hospitals and other providers; to provide assistance to rural communities to improve reimbursement through participation in the Rural Health Clinics program (see ch. 3) and establishment of skilled nursing facility beds; and to coordinate research on health status and morbidity. It was also required to make recommendations to the legislature by February 1990 on the development of a new alternative licensure category for rural medical facilities (*302*).

South Dakota—The South Dakota Office of Rural Health, established in 1988, has two offices: one within the State Department of Health, and the other within the University of South Dakota School of Medicine (*627*). The Office was created by a memorandum of agreement between the medical school and the Department of Health, and it receives funding through a State legislative appropriation. Additional funding is gained through the School of Medicine. Activities of the ORH include:

- recruitment and retention of rural health professionals;
- technical assistance to help rural providers establish and maintain rural practices, and to help rural facilities apply for Rural Health Clinic certification under Medicare and Medicaid;
- health care needs assessments for rural areas; and
- dissemination of rural health information to medical students and medical residents (*627*).

reported that they had developed task forces, most commonly through administrative action of the Governor's office. Table 4-13 provides some examples of State task forces and committees and their responsibilities. The experiences of New York and Texas, described below, illustrate the role of task forces in catalyzing legislative and administrative action on rural health issues.

NewYork

Both the State legislature and the State Department of Health have recently examined rural health care issues in New York. In spring 1987, the Legislative Commission on Rural Resources held a symposium to assess the rural health care system and to design a framework to ensure access to rural health for the next 20 years. The symposium identified three major areas needing legislative and administrative attention:

- need for regulatory flexibility (e.g., granting rural hospitals a waiver from the CON process),
- need for reimbursement and financing mechanisms that more accurately reflect costs and improve access to capital, and

Table 4-13—Four Examples of State Task Forces and Committees Created To Address Rural Health Issues

State	Name of task force/committee	Authority	Responsibilities
New York	Task Force on Rural Health Strategies	Administrative (1987)	▪ Examine rural health care issues and problems statewide ▪ Develop strategies and recommendations for administrative or legislative action
Washington	Washington Rural Health Care Commission	Legislative (1988)	▪ Review existing laws and regulations governing rural health services and identify barriers they create to efficient and effective delivery ▪ Review issues that affect the current delivery of rural health care ▪ Establish operational standards for a model alternative rural health facility and review the impact of existing government payment policies on such facilities
Alabama	Alabama Rural Health Task Force	Legislative (1989)	▪ Study and recommend to the legislature ways to address the problem of declining availability of obstetrical services in rural areas of the State ▪ Recommend ways to improve the financial health of rural hospitals delivering obstetrical care through better management practices, modified scopes of services, and other mechanisms
Texas	Special Task Force on Rural Health Care Delivery	Legislative (1987)	▪ Define minimally acceptable levels of medical care for the State's rural areas, focusing on specific issues in emergency medical transportation, hospital care, emergency and outpatient care, and ancillary services

SOURCE: Office of Technology Assessment, 1990. Data from: New York State Department of Health, Toward Improving Rural Health Care: A Report of the Task Force on Rural Health Strategies (Albany, NY: New York State Department of Health, November 1987); State of Texas, Special Task Force on Rural Health Care Delivery, Final Report and Recommendations to the Governor (Austin, TX: State of Texas, February 1989); J. Coleman, West Alabama Health Services, Eutaw, AL, personal communication, July 1989; Washington Rural Health Care Commission, A Report to the Legislature on Rural Health Care in the State of Washington (Olympia, WA: Washington Rural Health Care Commission, January 1989).

. need for coordination and community planning among State and local rural programs.

Other recommendations included increased State-level technical assistance to local providers in grant writing and services coordination.

A subsequent legislative commission found that many of New York's rural hospitals and nursing homes suffered from inadequate access to financing for major projects. The Commission recommended that information resources be enhanced, the CON review process for capital purchases be modified, and State-level capital financing prograrns be made more accessible to rural providers (439,440).

A State Department of Health task force created specifically to examine State rural health care issues and problems issued a report in 1987. Its recommendations included:

. improving migrant health services,
. promoting rural health networks,
. improving the supply and distribution of health personnel, and
. establishing a rural health council (437).

The findings and recommendations of these groups led to direct legislative and administrative action, including the establishment of two new statewide rural health entities. The Rural Health Council, which includes providers, consumers and elected officials who act as advisers, now oversees State-funded rural health programs and offers ideas on possible new initiatives. The Office of Rural Affairs works with State agencies to monitor new legislative programs affecting rural areas (391). The State has recently authorized appropriations for:

. small grants to providers in underserved areas who coordinate with other facilities to combine needed services and procedures;

- grants to rural hospitals for service diversification, expansion, conversion, or the development of various affiliations and alliances;
- a development program that helps rural providers plan and implement projects to improve existing primary care services or develop other essential services such as emergency medical care, rehabilitation, and long-term care;
- a program to expand primary care services in underserved rural areas and to make primary care accessible to medically indigent populations; and
- a swing-bed demonstration program for rural community hospitals (438).

Texas

In 1987, the Texas Legislature created a special task force to define minimally acceptable levels of rural medical care. Work groups addressed specific issues of emergency medical transportation, hospital care, emergency and outpatient care, and ancillary services. The task force's final report (issued in February 1989) described a crisis in the State's rural health delivery system, citing several hospital closures, a curtailment of obstetric services, and shortages of health personnel. The report's recommendations addressed trauma care, Medicaid reimbursement, capital finance programs for rural hospitals, and hospital diversification. The report also recommended creating a statewide center for rural health initiatives to promote integration of rural health programs and services into an overall system of care (574).

In 1989, the State legislature authorized the creation of a Center for Rural Health Initiatives within the State Department of Health to coordinate and develop rural health services in the State. The legislation also:

- established a Medicaid swing-bed program;
- allowed full implementation of the Federal Rural Health Clinics Act (Public Law 95-210) in the State;
- directed expansion of rural medical student and residency training programs;
- required hospitals to implement patient transfer agreements to prevent ''reverse dumping' of indigent patients; and
- indemnified physicians at least 10 percent of whose patients were on Federal or State medical assistance and mandated a malpractice insurance premium discount for such physicians (597).

Other State Initiatives

Initiatives in other States include a wide variety of programs aimed at coordinating and augmenting rural health care services. For example, some States are considering creating new health facility categories to enable small, struggling rural hospitals to restructure and narrow their scope of services (see ch. 8). Other examples are:

- *In Arkansas, the* State legislature recently appropriated new funds ($225,000) to an existing rural medical clinic loan fund for small communities that lack adequate medical services (54).
- *In Illinois, the* Department of Public Health recently issued a report on participation in the Rural Health Clinics program (see ch. 3). The report provided background on this program, identified areas where clinics would qualify for participation, discussed clinic certification procedures and reimbursement, examined the impact of certification, and outlined a plan for disseminating information on the program to rural providers (286).
- *In Iowa,* provisions of an extensive law passed in 1989 include:
  --creation of State Office of Rural Health (see box 4-A);
  —technical assistance by the Department of Public Health to help coordinate development of outreach centers for pregnant women and infants and children;
  —pilot programs in rural hospitals to provide primary and preventive health services to the medically indigent;
  ---expansion of agricultural health and safety programs;
  -expansion of mental health outreach services, homemaker/health aide programs, and public health nursing programs; and
  —authorization of the use of an existing tax levy for rural hospital operation and maintenance (302).
- In *Tennessee, the* Community Health Agency Act of 1989 authorized and appropriated $6 million for eight rural and four urban community health planning agencies. Each planning agency must define and help develop a regional

system of coordinated primary care services accessible to all area residents (594).

SUMMARY AND CONCLUSIONS

States have both a high level of involvement in rural health activities and a significant degree of dependence on Federal funding for those activities (table 4-3). The level of effort States are devoting to rural health issues varies dramatically and does not necessarily correspond with States' degree of ruralness or perceived level of need. Differences between ''more rural' and "less rural" States emerged primarily in the States' perceptions of major rural health care problems (table 4-10) rather than in their level of rural health-related activity. While some States boast a variety of successful initiatives and programs, other States—and, notably, some States in which a large proportion of the population is rural-have not mobilized to address their particular rural health problems. These States might especially benefit from Federal guidance, encouragement, and continued support.

Because the OTA survey did not attempt to describe the degree to which reported activities were felt to have been successful by the States, or the sources of funding for specific activities, it is impossible to distinguish clearly between the Federal and the State roles. A study conducted by the Federal Bureau of Health Professions in 1986 found that State support for health professions distribution programs increased significantly during the first half of the 1980s (685).[19] However, OTA's survey found that States still rely heavily on Federal funds to support a variety of existing rural health activities.

Most States identified provider recruitment and placement issues as high priorities, but most did not have programs (e.g., service-contingent loan forgiveness/repayment and scholarship programs) commonly believed to be most effective in addressing these issues. Because scholarships and loans are costly, such programs would probably require significant capital if they were to have a pronounced and prolonged impact.

When asked what activities or programs they would like to see in the future to address rural health issues, respondents to this survey often suggested an active Federal role. Activities such as the creation of State ORHs; development of rural health policies, plans, and standards; improvement of health insurance coverage; Medicaid expansion or reform; rural health systems coordination and network development; loan repayment or forgiveness and scholarship programs; and availability of rural-oriented health professions education were frequently mentioned. A Federal role is possible, if not implicit, in all of these initiatives.

Recent State legislative activity on rural health issues has ranged from energetic to nonexistent. Active States can provide valuable models for less active States, and certain State Programs 'could serve as models for broader Federal initiatives. OTA's survey of State rural health activities reveals some significant regional and State differences that may be useful in targeting Federal resources.

State ORHs provide focal points for State rural health activities and programs and can improve the development and coordination of local, State, and Federal efforts. The degree to which State agencies can effectively direct such offices, however, will vary depending on financial and organizational factors. The distribution and organization of current State ORHs suggests that any Federal support for the creation or operation of State ORHs should be flexible with regard to location of the ORH within the State. Some States currently without ORHs might consider alternatives to the State agency-based model (e.g., university-based ORHs like those in Arizona and North Dakota). South Dakota and Georgia are examples of States whose ORHs are based both within a State agency and a university.

[19]This study, as well as State efforts in health personnel recruitment and retention, are discussed in greater detail in ch. 13.