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The energy industries were generally depressed.

Despite these problems, we also see progress. For example this is a great time to be in Texas. Passage of the Omnibus Health Care Rescue Act with the many changes it mandates is very exciting for this State and others who need to look to it for guidance. I'm particularly pleased that our office was able to make some contributions to the recommendations to the legislative task force that Jim Brom, Chet Brooks and Mike Mckneey that were accepted recommendations by the Texas legislature under the leadership of Senator Chet Brooks and Representative Mike McKinney.

Introduction

We face many problems in rural health today and several are reflected in the agenda: problems of infant mortality, adolescent health and development, the problems of our enormous and growing rural elderly population, the fact that agriculture has become our most dangerous occupation,

the breakdown of emergency medical systems, chronic shortages of mental health professionals and programs to deal with mental health and substance abuse, and obstetrical services that are disappearing rapidly all across the American countryside. In addition blacks hispanics nature Americans and others face even greater problems of access.

As if these problems were not enough, thousands of rural communities in this country currently face a crisis in basic health care services. Some progress has been made with Federal help, State assistance, community support, and aid from the private sector. But significant problems remain.

Simply put, the two greater problems are (1) we are loosing our rural hospitals at a rapid rate, and (2) we have a chronic shortage of health professionals and primary care services in most rural areas.

Rural Hospitals

Let's look at them one at a time. Rural hospitals, particularly small rural hospitals -- those with fewer than 50 beds -- are struggling to survive.

We lost well over 200 rural hospitals in this decade nearly 100% of all rural hospitals. The number closing increased each year.

Recent changes to Medicare prospective payment have helped the sedation somewhat. The last three omnibus budget reconciliation bills that have been passed by Congress have provided much higher updates for rural hospitals than for urban hospitals. And there

uncompensated care that has fallen squarely on the shoulders of rural hospitals.

All three of these problems -- changes in hospital reimbursement -- the declining admissions rate -- and uncompensated care -- all of these must be addressed before rural hospitals can be expected to regain their viability.

I have a great deal about how these hospitals may not always be needed and I'm sure that's sometimes true but I put it to you that some urban hospitals probably aren't needed either and that the consequences of closures of rural hospitals are almost always greater for rural citizens than the closure of urban hospitals for urban residents.

Because in most rural communities there is only one hospital. In most cities there are lots of hospitals. What you will be told if you'll 're in a small town and your hospital closes is that's all right - there is another hospital only thirty or forty miles away. A friend of mine Sam Cordes of Nebraska recently told a Texas audience that by that logic we ought to propose to close all the hospital in Dallas. We could suggest to the people there that they get their care in worth. Its one thirty or forty miles away. Now your typical Dallas residence will find that to be a prepertpas suggestion. Well so do the residents of small towns when told that their health care system is folding. I've talked about progress we are making in higher Medicare payments. That's what we are doing about hospital at the Federal level.

On the other hand, uncompensated care is more of a State function. Small rural hospitals simply can't bear the tremendous burden alone, particularly at the rate it's growing. Nor can the physicians who serve rural areas and staff the hospitals there.

They cannot survive without being adequately paid for their service. <u>Expecting hospitals or physicians to do it alone is a perfect prescription for disaster.</u> Those in poor areas cannot provide the level of uncompensated services that is necessary and still maintain their service or practices in those areas.

Some States have recognized this and are trying to provide ways to protect the hospitals and/or the medical practices.

New York and Massachusetts, for example, have all-payers systems. They are designed so that all hospital patients in a given year help to pay for the care of those patients who can't afford to pay.

Florida has taken a little different approach.
Uncompensated care is funded by a Statewide uninsured pool, not unlike some uninsured motorist pools. this program provides

Mayors and town councils, prominent citizens, and young people can't be hypocritical in their support for their hospitals. They can't say one thing and do another. They have to demonstrate their support by patronizing these hospitals themselves instead of fleeing them for larger urban hospitals.

Hospitals themselves play a role. They need to be creative in their business arrangements. For example, some hospitals have developed cooperative programs with non-predatory, tertiary hospitals so that tertiary hospitals get the patients with open heart surgery and rural hospitals get technical assistance in return and outreach surgery, and professional consultations and so forth.

Hospitals also should consider joining together to form hospital systems like a cooperative of 19 small rural hospitals in Wisconsin. Five of the original nine were expected to close. But they were determined not to go down without a fight. They got hold of the bylaws of a dairy cooperative and formed a cooperative agreement -- one that goes beyond mere bulk purchasing -- and extends to the types of services they provide. For example, some specialize in obstetrical services while other focus on, say, orthopedics. They also join together to apply for grants from foundations and Federal and State governments because they've found that as a group they're more likely to be successful than as small, separate hospitals. I'm happy to report that none of the original hospitals has been forced to close since the inception of the cooperative agreement 6 years ago.

In addition, rural hospitals need to develop more aggressive marketing strategies -- using radio and television at times, as well as aggressive community campaigns.

Hospitals need to be promoted within their communities. And citizens need to know that if they don't support their hospitals, they'll lose them and the access to health care they afford.

Health Professional Shortages

The second critical issues in rural health is the shortage of health professionals and inadequate access to primary care in rural areas.

Similarly, when we examine those issues -- we find that, as with hospitals and their financial stability, neither the problems nor the solutions are simple.

A recent study performed at the University of Wisconsin showed that in 1985 in small communities, there were 53 physicians for every 100,000 residents. But for the nation as a whole, there were 163 physicians for every 100,000 people. The researchers

feedback from all across the country is that there are shortages almost everywhere.

Mental health personnel also are in short supply in many areas. A six-State study by the National Center for Social Policy and Practice found that in 24% of the counties, there were neither psychiatrists, psychologists, nor social workers.

The Federal government has developed a number of programs over the last several years that have been important to rural professional and access to care.

The National Health Service Corps has been partially converted from a medical scholarship program to a loan repayment program that repays medical students and nurses loans in return for service in manpower shortage areas. This year the corps is up for reauthorization and many in Congress are committed to increasing its strength partially the scholarship program. At out time 10% of all medical students were with the corps and were obligated to services in the rural areas.

The 600 community and migrant health centers across the country serve almost 3 million rural Americans. Under this program financial assistance is given to community group practices to help them pay the salaries of physicians in areas where the economic base is insufficient to support them.

Community health centers are then required to implement a sliding fee scale so that patients who are unable to pay the full fee can receive services at a discounted rate. These are a large number of community and migrant health centers in Texas and you will hear more about them later today.

Federal health professions education programs that support the training of physicians, nurses, social workers, and health educators, as well as Area Health Education Centers, are important to rural areas.

With the disproportionately high levels of older people in rural areas, area agencies on aging are important to health maintenance with Federal support as their principal mainstay.

One additional Federal initiative -- the increase in basic encounter rates for rural health clinics -- has helped to stabilize rural health care in many rural communities. Rural health clinics are simply private group medical practices in rural areas that employ nurse practitioners, nurse midwives, and physician assistants in systems of care and, thus, qualify for higher Medicare payments both for the mid-level providers and the physicians.

It's a homegrown solution out of Montana. But I think it's the type of innovative approach we need to be looking for. It may be applicable to other States. Currently, more than 20 States are monitoring the Montana experience and considering whether to take a similar approach. Already Wyoming has passed a law defining MAFs under its Medical Facilities Act and Florida has proposed creating emergency care hospitals similar to MAFs. And of course the Congress has recognized this experiment and authorized a similar experiment.

Montana's not the only State looking for solutions to rural health problems. Here in Texas the Texas Legislature in 1987 appointed a commission to study and make recommendations on rural health issues. I had the opportunity to testify before that commission and meet with Senator Brooks and Lt. Governor on rural health issues in 1988. As you know, the commission's recommendations have led to the passage of a comprehensive rural health care act in Texas, including establishing one of 22 State Office of Rural Health so far created.

The Governors of Michigan and Georgia also established task forces in 1987 to study rural health care and make recommendations on how it could be improved. Many changes have resulted from the recommendations of these groups, including the 18th Office of Rural Health in Georgia.

States bear a lot of responsibility. Some States have developed procedures for monitoring their medical schools to ensure that a high percentage of graduates remain in-State, particularly those who specialize in family medicine, general pediatrics and general internal medicine.

The University of Minnesota Medical School, for example, sends a large number of 3rd-year medical students into rural community practices under the preceptorship of rural physicians for 9 months. The students score just as well on 4th-year exams and national tests as other medical students. And since 1971, 57% of program participants have returned to practices in rural Minnesota.

South Carolina has a scholarship program much like the National Health Service Corps program. It places graduates from the University of South Carolina Medical School into underserved areas.

South Dakota has a State/community partnership program. The community identifies a potential medical student -- the State and the community share the costs of medical school -- and then the student returns to the community to practice.

Health. The Committee is headed by former Governor Robert Ray of Iowa. The Committee has begun to make recommendations to the Secretary, and higher payments for small rural hospitals and rural physicians are its priority. they have also endorsed revitalization of the National Health Service Corps and continued Federal support for health professions education.

I started by saying these are worldwide problems and I believe they are. I have talked with officers of Japan and Scotland and Paraguay and Canada in recent years and all face problems of providing essential services - health services in particular - in rural areas

If we are going to solve these problems and continue our progress, we need to learn from each other.

Paraguay for example uses flying squads of doctors and nurses and other health personnel who are flown out from Assuncion each day to remote villages. Within an hour of arrival tents are created and patients are being seen. Within a few hours the tents are collapsed and the squad is flying to another village. What is wrong with a model like this for small communities in Western Kansas or in Nevada? Why could it not be the cost effective basis of a system of care for frontier areas.

In Iowa today new approaches are being taken to improve agricultural health and farm safety. If a farmer presents himself at a special hospital clinic with a pesticide burn he will not only receive treatment, he will receive a visit to help him with pesticide management so that future burns may be prevented. Physicians work together with occupational nurses, safety engineers, physiotherapists, to solve problems and prevent reoccurrences. I said this was a new program and it is for Iowa. But it based on a Swedish model that goes well beyond what is generally available in farm communities in this country.

We need to learn from each other, we need to advocate and we need to persevere because progress is slow. Rural residents are only one quarter of American citizens but 65 of 100 U.S. Senators now are members of the Senate rural health caucus. 100 of the 435 members of the House of Representatives are members of the House Coalition on Rural Health Care. We need to see that number increased. We need to pay equal attention to State Legislative.

We need to support the efforts of the National Rural Health Association in Washington and the Texas Rural Health Association here in this State. We need State offices of rural health in every State.