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Rural Focus

A Glimmer of Hope for Rural Obstetrics

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Emerging Obstetrics Crisis

Recent headlines like *The New York Times*' "Rural Hospitals Are Shuttering Their Maternity Units," CNN's "Maternity Units Are Closing Across America," and the Office of Rural Health's "Nearly Half of Rural Hospitals Lose Money on Childbirth" paint a bleak picture for access to obstetrics services outside of America's cities. When a rural facility closes its obstetrics unit, mothers can face 100-mile drives, exacerbating the U.S.'s already abysmal infant and maternal mortality rates. The Commonwealth Fund recently found that while the U.S. spends far more on healthcare than any other high-income country, we have the worst infant and maternal mortality rates in the group.[1] While much of the focus on that dichotomy has been on access for the urban poor, less consideration has been given to what have been dubbed as "maternity care deserts" confronting large swaths of the country.

Rural communities are facing a crisis in access to obstetrics.

As transaction advisors regularly working with rural facilities considering partnerships, it is not unusual for us to hear worried board members voice suspicions that system partners will cut services and divert volumes to hub facilities—that joining a larger system will result in their hospital becoming a "band-aid station." These concerns might seem to make intuitive sense—once control shifts from a local board that understands the critical role healthcare plays in a given community, wouldn't financial interests naturally trump access and mission? Our past research has shown this not to be the case. Statistical analysis reveals that community hospitals that belong to systems have higher case mix indexes than similarly sized and positioned standalone facilities.[2] However, we had not looked specifically at rural facilities or the growing obstetrics crisis in these communities.

1 Roosa Tikkanen, et al., "Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries," The Commonwealth Fund, November 18, 2020.

2 "Assessing Hospital Preparedness for COVID-19 by Affiliation Status," Juniper Advisory, May 28, 2020.

Exhibit 1: Number of Acute Care Hospitals

U.S. Acute Care Hospitals			
	Independent	**In System**	**Total**
Rural Hospitals	791	1,051	1,842
Non-Rural Hospitals	419	2,884	3,303
Total	**1,210**	**3,935**	**5,145**

Of the country's 5,145 acute care hospitals, there are 1,842 sole community providers and/or critical access hospitals serving rural populations (see **Exhibit 1**). Of these rural hospitals, 57 percent are in systems and 43 percent are standalone facilities. That is a much lower percentage of system hospitals than found in non-rural areas, where 87 percent of hospitals are in systems. Certainly, a range of factors, including supplemental reimbursement, have led to an outsized proportion of rural hospitals remaining standalone, but our experience indicates that a belief that systems are less likely to sustain services is central to the thinking of many rural hospitals focused on remaining independent. As illustrated in **Exhibit 2**, this concern is unfounded in the case of obstetrics.

Rural hospitals that belong to systems are more likely to offer obstetrics. This may be, in part, the result of hospital systems reinvesting profits into under-reimbursed, but desperately needed services.

Exhibit 2: Hospitals with Obstetrics

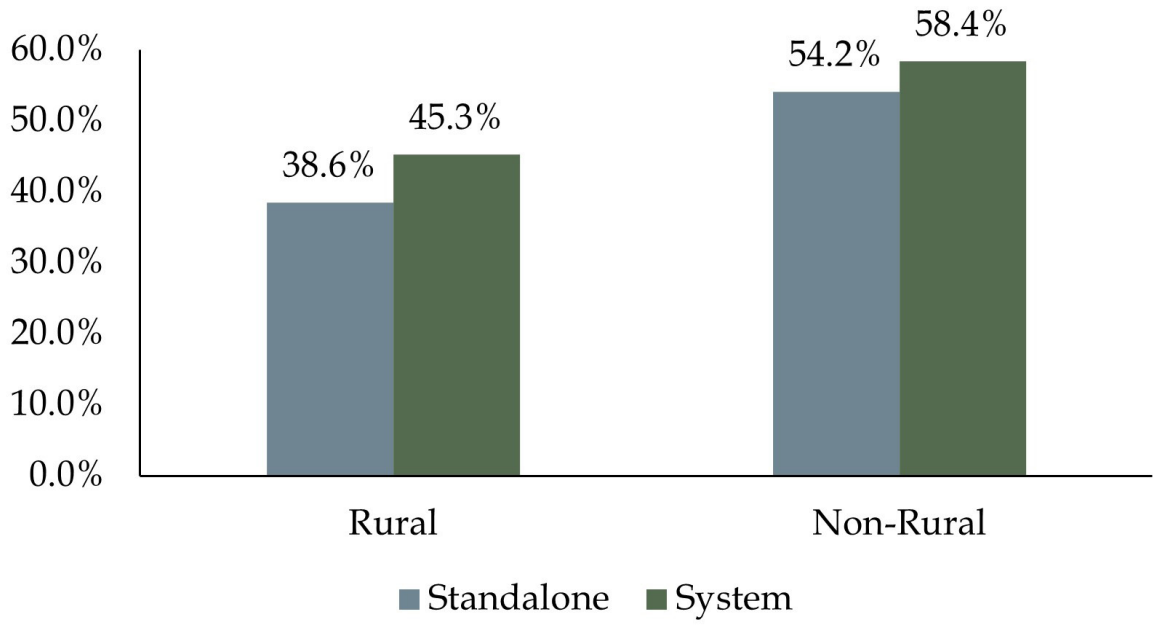
U.S. Acute Care Hospitals			
	Independent	**In System**	**Total**
Rural Hospitals[1]	791	1,051	1,842
Rural Hospitals[1] w/ Obstetrics	305	476	781
% of Rural Hospitals[1] w/ Obstetrics	**38.6%**	**45.3%**	**42.4%**
Non-Rural Hospitals[2]	419	2,884	3,303
Non-Rural Hospitals[2] w/ Obstetrics	227	1,685	1,912
% of Non-Rural Hospitals[2] w/ Obstetrics	**54.2%**	**58.4%**	**57.9%**

1. Rural acute care hospitals are defined here as critical access hospitals and short-term acute care hospitals with sole community provider status.
2. Non-rural acute care hospitals are defined here as short-term acute care hospitals without sole community provider status.

While nearly 60 percent of non-rural hospitals offer obstetrics, only 42.4 percent of rural hospitals have obstetrics programs. However, this understates the access issue for rural hospitals. By definition, these sole community providers and critical access hospitals are the only local option for their communities. While a given hospital in an *urban* market closing its obstetrics service may mean that patients need to travel a few extra miles, a similar *rural* closure could have a much more devastating impact on access.

Rural hospitals that have joined systems are more likely to offer obstetrics than their standalone peers—45.3 percent of rural hospitals that are a part of a system offer obstetrics compared to just 38.6 percent of standalone facilities (see **Exhibit 3**). This is also true for non-rural hospitals, but to a lesser extent with 58.4 percent of system hospitals offering obstetrics versus 54.2 percent of standalones.

Exhibit 3: Obstetric Services Offered



Similarly, of the hospitals that report whether they have a neonatal intensive care unit (NICU), system-owned rural providers are nearly four times more likely to have NICUs than those that are standalone. This same disparity exists in urban areas.

Why Are Systems More Likely to Offer Obstetrics?

There are a number of likely drivers that lead systems to offer obstetrics in rural areas. First among these is that systems have been shown to have lower costs than standalone hospitals. As the majority of these hospitals are not-for-profit, by definition they need to reinvest profits in their missions—providing healthcare to the communities they serve. Unlike other mature industries, where higher profits would most typically be distributed to investors, not-for-profit hospitals are required to keep those profits within their businesses by doing things like subsidizing the financial losses of obstetrics programs in rural areas of high need.

These sole community providers and critical access hospitals are the only local option for their communities. While a given hospital in an *urban* market closing its obstetrics service may mean that patients need to travel a few extra miles, a similar *rural* closure could have a much more devastating impact on access.

Board Discussion Questions

- Are obstetrics services at risk in our community?
- How does offering obstetrics impact the prosperity of our region?
- How can we ensure access to obstetrics?
- What are the trade-offs between maintaining standalone governance and access to care?

While the U.S. spends far more on healthcare than any other high-income country, we have the worst infant and maternal mortality rates in the group.

Health systems may also be better positioned to recruit obstetricians. They have larger provider networks and recruitment engines they can leverage to provide coverage in challenging rural markets. The ability to recruit obstetricians to rural markets can be particularly pronounced, especially as these programs tend to be smaller and the call schedules physicians face with smaller practices can be wearing. For example, system hospitals may be better positioned to access occasional call coverage than their standalone peers, lessening the burden when an obstetrician takes scheduled vacation or another gap presents itself.

Systems also typically have more robust marketing resources to foster trust between the mother and her care team. Even small differences in market share from the edges of a service area can make the difference between a sustainable program and one that closes.

Conclusion

While much has been written about how system hospitals are financially stronger than standalone facilities, less attention has been paid to how systems reinvest those profits in their businesses. One area where those system resources are having a direct impact is with obstetrics services in rural communities. While hospitals joining systems will not solve the rural obstetrics crisis in and of itself, consolidation in the industry and the way systems focus resources on access appears to be helping. Given these findings, boards of standalone facilities should assess whether a system partnership could increase access and advance their organization's mission.

The Governance Institute thanks Jordan Shields, Partner, Casey Webb, Managing Director, and Duncan Cannon, Analyst, of Juniper Advisory for contributing this article.
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