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Federal Assistance and Rural Hospital Closings: The Impact of the USDA Community Facilities Program

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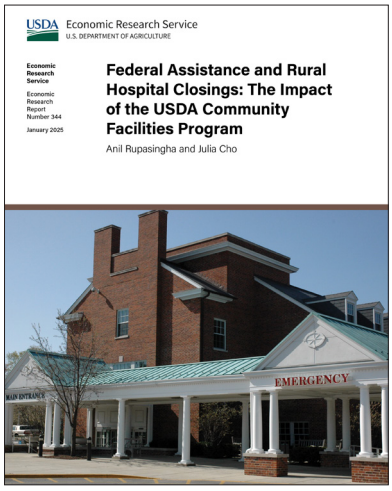

What Is the Issue?

Rural hospital closings in the United States continue to be a concern for policymakers, community development practitioners, and rural residents. The authors of this report found that 146 hospitals in nonmetro counties in the United States have either completely closed or been converted to non-acute care (i.e., stopped providing general, short-term, acute inpatient care) since 2005. Of the 146 closures, 81 were complete hospital shutdowns, with the remaining institutions undergoing "hospital conversions" that eliminated inpatient services but kept other services (e.g., emergency care, outpatient care, primary care, or urgent care) operational. Compared with their urban counterparts, U.S. rural hospitals face financial stress due to several unique conditions: Hospitals in rural areas are usually smaller, more vulnerable to fluctuations in the economy, and have lower occupancy rates. As a result, their profit margins are generally lower compared with those of urban hospitals. The Federal Government, through various agencies, administers multiple policies and programs that provide financial support for rural hospitals. The Community Facilities (CF) Program is administered by USDA, Rural Development and comprises one of the major Federal programs providing financial assistance to rural hospitals. Despite the investments by these programs and the length of time they have been active (since 1972), the authors could find only one published study that investigated their impact. The objective of the present study is to investigate the impact of the CF Program on rural hospital closures.

What Did the Study Find?

The authors found evidence that investments by the CF Program have helped recipient hospitals survive longer than a comparison group of similar nonrecipient hospitals in nonmetro counties; the probability of survival of similarly situated hospitals is higher for those that received CF funding than those that did not. When accounting for the year of program investments after 2000, hospital-specific observable factors (e.g., age and size) and unobservable factors (e.g., revenue and number of beds), the program-recipient hospitals in nonmetro counties were 94 percent less likely to close 6 years after the receipt of funding than were the group of similar nonrecipient hospitals. The effect of program support on hospital survival dropped with time; program recipients were 90 percent less likely to fail than nonrecipients after 8 years, and 88 percent less likely to fail after 10 years. Due to several limitations in the estimation approach and data,

these findings should be evaluated with caution. These limitations include the incomplete capture of hospital-level attributes in the business data, the potential confounding influence of other Federal financial programs, the exclusion of newly constructed hospitals from the sample, the inability to differentiate between hospital closures and conversions (cessation of inpatient services), and inherent limitations of the exact matching technique employed.

How Was the Study Conducted?

To estimate the impact of the CF Program on rural hospital survival, administrative data from USDA's Rural Housing Service were combined with establishment-level data from the National Establishment Time-Series database. The empirical analysis was based on estimating a discrete-time proportional hazard model of hospital closures on a matched sample of hospitals that provided a valid counterfactual. The matched sample was obtained using exact matching methods and required that both program-recipient hospitals and nonrecipient hospitals be in the same State and same Rural-Urban Continuum Code, of the same establishment-type category, the same age group, and the same employment size during at least 3 years prior to the CF Program implementation.