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ABSTRACT

Supporting the premise that rural communities require functioning health care systems for their physiological, emotional, and economic well-being, the First Statewide Legislative Symposium on Rural Development defined problems and established goals for rural health care in New York. Despite increases in New York's overall physician supply during the 1970's, major changes have not occurred in the rural primary care specialties: general and family practice; general internal medicine, surgery and anesthesiology; and general pediatrics. The number of small, rural hospitals of less than 50 beds is dwindling. Increased emphasis on specialty training, rapid growth of medical technology, licensing regulations and practice constraints for health care providers have limited the number and type of personnel that rural hospitals can recruit and retain. The larger proportion of the elderly in rural areas also contributes to the rural health care crisis. State policymakers should develop and implement a flexible planning and regulatory framework that satisfies the health care needs of individual rural communities and improves the supply of health professionals. Public policy should consider how local involvement in the planning, design, implementation, and maintenance of rural health care can be enhanced. The report contains supporting maps, graphs, and charts. (NEC)

RURAL HEALTH CARE IN NEW YORK STATE:
A PRELIMINARY REPORT

NEW YORK STATE LEGISLATIVE COMMISSION ON RURAL RESOURCES
SENATOR CHARLES D. COOK, CHAIRMAN

FEBRUARY 1, 1984

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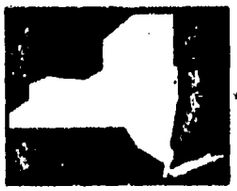
RURAL FUTURES



LEGISLATIVE COMMISSION ON RURAL RESOURCES
STATE OF NEW YORK
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The Commission on Rural Resources was established by Chapter 428 of the Laws of 1982, and began its work February, 1983. A bipartisan Commission, its primary purpose is to promote a state-level focus and avenue for rural affairs policy and program development in New York State.

The Commission provides state lawmakers with a unique capability and perspective from which to anticipate and approach large-scale problems and opportunities in the state's rural areas. In addition, legislators who live in rural New York are in the minority and look to the Commission for assistance in fulfilling their responsibilities to constituents.

The Commission seeks to amplify the efforts of others who are interested in such policy areas as agriculture; business, economic development, and employment; education; government and management; environment, land use, and natural resources; transportation; housing, community facilities, and renewal; human relations and community life; and health care. It seeks to support lawmakers' efforts to preserve and enhance the state's vital rural resources through positive, decisive action.

In order to obtain a clearer picture of key problems and opportunities, the Commission invited people to informal discussions at a Statewide Rural Development Symposium, held October 5-7, 1983. It was the first such effort of its kind in the state and nation. Workshop participants undertook in-depth examinations of key policy areas the Commission believed were critical to the state's future rural development.

Symposium participants focused their discussions on ends, not means. In short, the objective was to identify key trends, strengths, weaknesses, goals, and opportunities for advancement; not to present solutions. Once a clearer picture of these findings is drawn, the next step will be to identify and propose the required, and hopefully innovative, recommendations. This task will be the subject of a second, follow-up symposium. Another unique feature of the first symposium was the opportunity it provided participants to share their thinking with colleagues from throughout the state over a three-day period of intensive dialogue.

The Commission is happy to announce that the objective of the Symposium was accomplished. Preliminary reports, based on the findings, are being issued as planned, in connection with a series of public hearings it is sponsoring across the state. The aim of these hearings is to obtain public commentary on the preliminary reports. Following these, a final symposium report will be prepared for submission to the Governor and the State Legislature. It will also serve as a resource report for the second statewide symposium on recommendations.

The Commission is comprised of five Assemblymen and five Senators with members appointed by the leader of each legislative branch. Senator Charles D. Cook (R.-Delaware, Sullivan, Greene, Schoharie, Ulster Counties) serves as Chairman. Assemblyman William L. Parment (D.-Chautauqua) is Vice Chairman and Senator L. Paul Kehoe (R.-Wayne, Ontario, Monroe) is Secretary. Members also include: Senator William T. Smith (R.-Steuben, Chemung, Schuyler, Yates, Senaca, Ontario); Senator Anthony M. Masiello (D.-Erie); Senator Thomas J. Bartosiewicz (D.-Kings); Assemblywoman Louise M. Slaughter (D.-Monroe, Wayne); Assemblyman Michael McNulty (D.-Albany, Rensselaer); Assemblyman John G.A. O'Neil (R.-St. Lawrence); and Assemblyman Richard Coombe (R.-Sullivan, Delaware, Chenango).

PREFACE

The Legislative Commission on Rural Resources publishes herein one of nine preliminary reports from the First Statewide Legislative Symposium on Rural Development held October 5-7, 1983. This effort was not only a "first" for New York State, but for the nation as well.

The purpose of the Symposium, and the public hearings that will follow, is to catalog the strengths of rural New York, to define its problems, and to establish goals for the next two decades. Neither the Symposium nor the hearings will deal with strategy to develop our resources, address our problems, or accomplish our goals. That will be the thrust of a later Commission effort.

For the moment, it is our purpose to foster as objectively and exhaustively as possible, an understanding of where we are and where we want to go.

The Symposium reports in each subject area encompass the oral and written findings of the respective workshops, along with responses given at the Commission hearing where the reports were presented to State legislators for comment and discussion. Incorporated into this preliminary report is subsequent comment from group participants on points they felt needed amplification. Also appended to the published product is basic resource material intended to clarify points made in the reports.

I wish to personally congratulate the Symposium participants on the very sound and scholarly documents they have produced. However, their work is only preliminary to the final product which will be issued by the Commission once the hearing process is complete.

Those who read this report are urgently invited to participate in the public hearings that will be held throughout rural New York, or to submit comments in writing to the Commission. Your support, disagreement or commentary on specific points contained in the Symposium report will have a strong influence on the final report of the Commission.

Please do your part in helping to define sound public policy for rural New York during the next two decades.

Senator Charles D. Cook

Chairman

Legislative Commission on Rural Resources

INTRODUCTION

The quality and proximity of health care is critical to rural New York. An adequate health care system is one component of the community-social fabric that enables people to live and realize their potential in rural areas. Moreover health care providers interact powerfully with other important components of rural development, particularly business and employment, transportation, and education. Thus, rural communities require functioning health care systems for their physiological, emotional, and economic well-being.

Despite increases in New York State's overall physician supply during the last decade, major changes have not been achieved in the rural primary care specialties - general and family practice; general internal medicine, surgery, and anesthesiology; and general pediatrics. Another alarming trend that has been evidenced during the last 10 years is the dwindling number of small, predominately rural, non-teaching hospitals of less than 50 beds. Although serious equity issues have arisen concerning rural hospital closures, the hospital industry is likely to continue its emphasis of the past 15 years to reduce the total number of hospitals in New York State.

The importance of the rural hospital cannot be over-emphasized; it is a vital component of the rural health care system and an important institution in the rural community from a functional, symbolic, and economic perspective. The rural hospital works closely with the church and school as elements through which rural communities define themselves. This strong capacity for the planning and integration of services at the local level encourages a community-wide commitment to volunteerism in many rural areas.

Yet, serious problems underlie the viability of rural health care. The

current economic vulnerability of rural hospitals is attributable, in part, to the fact that many of these institutions are technologically obsolescent with respect to their facilities and equipment. Still, rural hospitals face numerous problems in their attempts to incorporate new technology. In addition, health industry factors such as the increased emphasis on specialty training, rapid growth of medical technology, licensing regulations and practice constraints for health care providers have limited the number and type of health personnel that rural hospitals can recruit and retain.

Another weakness contributing to the overall rural health care crisis is the fact that rural areas have a larger proportion of the elderly population than do their urban counterparts. The sparsely settled rural population base generally has not been served by the wide and growing spectrum of health and social service programs that have recently been developed for the elderly. This problem is further exacerbated by the current emphasis on health care cost containment which militates against improved access to health care services, for those rural areas with significant needs.

The Symposium group suggests that a chief goal for state policymakers is to develop and implement a flexible planning and regulatory framework that satisfies the health care needs of individual rural communities. Another goal is to improve the supply of health professionals. For example, an increased role for nurse practitioners would certainly alleviate low physician-to-population ratios in rural communities.

A key public policy question that will require further discussion by lawmakers is how local community involvement and support in the planning, design, implementation and maintenance of rural health care can be enhanced. A related issue concerns the difficulty of coming to grips with the true underlying problems of rural health care if strategies do not distinguish

between rural and urban areas. A case in point concerns the feasibility of increased educational requirements for the licensing of nurses and other health professionals. Such requirements, regardless of their noble intentions, must be weighed against the potentially adverse effects they might pose for rural communities, where registered nurses are already in short supply. Symposium participants felt that the special problems and opportunities associated with rural areas should be considered when health-related programs are designed and administered.

WHERE RURAL NEW YORK IS TODAY

Trends

- During the 1970's, rural counties in New York State experienced population increases - a turnaround of the seemingly inevitable dissipation of the rural populace.
  - The transition underway in rural areas will have important implications for the future status of rural health care systems;
  - The resurgence of rural life, sustained by emerging decentralization in our society, should help to make this decade a productive one for improving health care delivery in rural areas;
  - The associated demographic shifts will heighten the need for rationally planned rural health systems and will increase the potential for significant involvement of the rural populace for designing the health care and other social systems it will use.
- Rural populations have traditionally lagged behind more densely populated regions in the acquisition of basic social services, including health care.
- The increased overall supply of physicians has not resulted in major changes in the population of physicians in the primary care specialties - general and family practice; general internal medicine, surgery, and anesthesiology; and general pediatrics.
  - For example, in 1982 only 38% of physicians in New York State were in primary care specialties providing basic medical services.
- During the past five years, the dwindling supply of general practitioners has begun to be replaced by recently trained family practitioners and other specialists.
  - An encouraging proportion (more than 1/3) of recent family practitioner residency graduates are locating in non-metropolitan areas;
  - In the areas of primary care, the residency trained family practitioner will solidify his/her role as the core of the rural physician supply;
  - There will be a continued reemphasis of the generalist role in rural health despite educational and regulatory forces (e.g., specialization and credentialing) which militate against the production of the confident generalist;

- Recent research indicates that board certified specialists are beginning to migrate to non-metropolitan areas;

- The internist and pediatrician allied with the rural hospital also provide potent family care and must be equally encouraged in rural areas. The team of obstetrician and pediatrician is essential for the maintenance of a safe newborn service, while the surgeon is vital to the survival and safety of the rural hospital.

- Yet, despite the aforementioned gains, those areas with the fewest resources and the greatest need for physicians (counties with population under 50,000), still have great difficulty in attracting family practitioners or specialists to their regions.

- Rural areas will start to consider the use of alternatives to the traditional physician entreprenurial model including hospital-based primary care, the use of non-physician health care providers (e.g., nurse practitioners) in remote areas, and the use of state and local health departments for the direct provision of primary care.

  - Targeted approaches for rural areas or populations with special problems will slowly replace the comprehensive efforts of the 1970's aimed at improving access to primary care services in rural areas.

  - Tradional fee-for-service systems have started to be replaced by a relatively new concept which allows for the provision of comprehensive care to large groups of people through specific health care facilities at predetermined negotiable rates. Examples of these systems include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). The feasibility of HMOs and PPOs in rural areas is unclear at this point.

- In the past decade, the number of small and predominately rural hospitals of less than 50 beds has considerably diminished, whereas sizable growth has been achieved in the number of hospitals with greater than 200 beds.

  - Approximately one-fifth of rural community hospitals in New York have closed during the past decade. This trend is expected to continue to pervade the rural hospital industry during the 1980's;

  - The hospital industry will probably continue its emphasis of the past 15 years to reduce the total number of hospitals;

  - The decrease in the number of hospitals will take place mainly among small non-teaching hospitals, most of which are currently located in rural areas;

  - Rural hospitals have been natural targets for closure despite

questions concerning the cost-effectiveness from both a national and local perspective;

- Rural hospitals often make a significant contribution to the local economy, and the actual impact of a closure would depend upon the adaptation of the community following closure.

- Many rural hospitals currently must cope with declining occupancy rates, a decreased patient day base, and decreased patient revenues.

  - The above symptoms of a fiscally-troubled institution have resulted in increased average costs per patient day in rural hospitals, although such costs are less than those evidenced in larger urban hospitals;

  - Dramatic increases in the cost of hospital care have led to sizable increases in regulatory efforts.

- The aging of the population and the growing number of people retiring in rural areas guarantees that providing health and social services for the elderly will remain a major challenge for rural communities.

- States will play an increasingly important role in the improved integration of local rural health systems as the federal government reduces its previous active role.

Strengths and Assets

- The quality of rural life: particularly the integrity, quiet strength and compassion inherently found in small-town life and social services delivery.

- Diversification of practice and experience; wide range of skills required by rural health providers indicates the need for a broad training background.

- Capacity for planning and integration of services at the local level; there is strong local commitment to community hospitals and other health care institutions.

- The rural hospital is a vital component of the rural health care system and an important institution in rural communities from a functional, symbolic, and economic perspective.

  - The hospital works with the church and school as elements through which rural communities define themselves;

  - A strong community-wide commitment to volunteerism is prevalent in many rural areas - active, local community groups are linked into networks which aid rural hospitals.

- Cost-effectiveness in delivery of certain health care services.
  - Care is available at more reasonable rates;
  - Unnecessary laboratory testing is avoided;
  - More time is spent attending to the individual patient's needs.

Weaknesses and Problem Areas

- Lack of flexibility in the health care system, which is working to the disadvantage of users and local providers.
- The viability of the rural hospital.
  - The economic stability of the rural hospital will remain tenuous. The scope and quality of services they provide depend largely upon the local supply of health personnel, access to capital, and the ability to incorporate the appropriate technology.
  - Factors such as the increased emphasis on specialty training, rapid growth of medical technology, licensing regulations, and practice constraints for non-physician health care providers have limited the number and type of health personnel that rural hospitals can recruit and retain.
- Although the modern day hospital embodies the nature of our current technological society, the small rural hospital has been truly disturbed by technological expansion. Patients and providers often expect new technology to be available in their local hospital. However, the burden of utilizing expensive technologies for sparse populations can be overwhelming.
- The maldistribution of health resources is not easily overcome. For example, rural areas depend heavily on the training of sufficient generalists to assure an adequate supply of health manpower, yet training institutions place a primary emphasis on the specialist.
- Health professionals in rural areas have encountered difficulties in obtaining access to continuing education in efforts to upgrade their skills.
- Shortage of nursing personnel.
  - In particular, rural hospitals have experienced problems attracting adequate registered nursing personnel, especially those both capable and willing to assume the diverse and complex tasks required in the rural hospital environment. The shortage of health personnel in rural areas increases the range of skills required of nurses.

- The educational thrust of urban training programs often lack relevance to the needs of rural hospitals.

- Many rural hospitals are, at present, technologically obsolescent with respect to their facilities and equipment. These hospitals face numerous problems in their attempts to incorporate new technology:

  - Including insufficient funds for the sizable capital expenditures required for new technology;

  - lack of adequately trained personnel and inability to provide inhouse education and training resources;

  - and lack of sufficient utilization to justify the large fixed costs of state-of-the-art equipment and associated personnel.

- The current emphasis on health care cost containment will militate against improved access to health care services, in those rural areas with significant needs.

- Rural areas have a larger proportion of the elderly population than do urban areas.

  - The rural aged have lower incomes, less mobility due to poor transportation facilities, and poorer health status than do their urban contemporaries;

  - Proper care for the elderly and other chronically ill is poor at best;

  - The relatively sparse population density in rural areas generally cannot support the wide and growing spectrum of health and social service programs that have recently developed for the elderly.

- Most rural communities cannot generate enough demand to support multiple overlapping health care systems (e.g., linkages for secondary and tertiary care).

  - Rural communities cannot afford the luxury of multiple single-purpose programs; yet existing linkages between programs have not been adequately forged at the local level.

- It is difficult to alter the basic way medical services are provided without accompanying changes in reimbursement policies. There is an urgent need to improve financing and the regulatory framework for primary care services (e.g., current institutional barriers hinder the formation of hospices in rural areas).

- Capital financing for construction projects and equipment purchases will become more difficult to obtain for many rural hospitals for

a number of reasons, including:

- Reductions in philanthropy and government support;
- Restrictions on the use of tax-exempt securities for debt financing of small rural hospital construction projects;
- High interest rates which will reduce borrowing potential;
- Inadequate internally-generated revenues.

- Wide sudden swings in public policy have accompanied the ebb and flow of governmental attention to rural health care. These fluctuations have not been conducive to the development of stable rural health care systems.

GOALS FOR RURAL NEW YORK

- A flexible planning and regulatory framework that meets the needs of rural communities. Rural hospitals will undoubtedly continue to play a central role in rural health care systems but they will have to retain flexibility in order to adapt to a rapidly changing and unpredictable future.
- Continued development of cost-effective alternatives to institutional care for the elderly and chronically ill.
- Improved supply of health professionals and a stable health care system to support them.
  - Recognition of the importance of rural hospitals in attracting physicians to rural areas.
  - Maximize the role of nurse practitioners in institutional and non-institutional settings;
  - Recognize the economic impact of increased educational requirements for licensing of nurses and other health professionals.
- Improve telecommunication linkages in order to reduce transportation distances and thus make health care more accessible for the rural populace.
- Strengthen the role of preventive health care and seek to integrate the activities of local health departments with public and private providers.
- Improve the support system for geriatric and other training programs that address the needs of rural populations.
- Develop cost containment policies that do not overburden rural health care delivery systems.

- Encourage more flexible reimbursement policies that allow the development of alternatives to traditional health care systems.

- Improve local planning capabilities to insure the delivery of appropriate services.

- Improve linkages to assure access to appropriate secondary and tertiary services.

- Support and enhance rural ambulance/first response corps.

PUBLIC POLICY QUESTIONS TO BE ADDRESSED

- The decentralization of responsibility for program management and operation is a desirable trend that should be reinforced. How can local community involvement and support in the planning, design, implementation, and maintenance of rural health care be maintained and enhanced?

- Approaches that attack one particular aspect of the rural primary care problem, such as the lack of appropriate personnel or facilities, often provide fragmented short-term "solutions" to long-term problems. How can the temptation to deal with immediate concerns be carefully balanced against the need for thoughtful long-range planning?

- How can the rural hospital be aided in its efforts to deal with a complex set of incentives and disincentives as it seeks to utilize new technology?

- How can hospitals be encouraged to assume the role of a "conduit for change" in the rural health care system?

- How will public policymakers obtain a clear set of guidelines that will assist them in becoming steadier and more effective partners in efforts to improve rural health care? For instance, it is difficult to come to grips with the true underlying problems of rural health care by using strategies and regulations that do not distinguish between rural and urban needs and conditions.

- The current focus on cost containment suggests careful consideration be given to modifying the existing number and type of health professionals being trained. How can the training, licensure, and reimbursement of health professionals be made more responsive to rural requirements and constraints?

- There are many very small rural communities where the aggregate demand is insufficient to support any permanent health care system. Do federal and state governments have a responsibility to identify and support basic health programs in areas that will never be able to totally defray their own costs?

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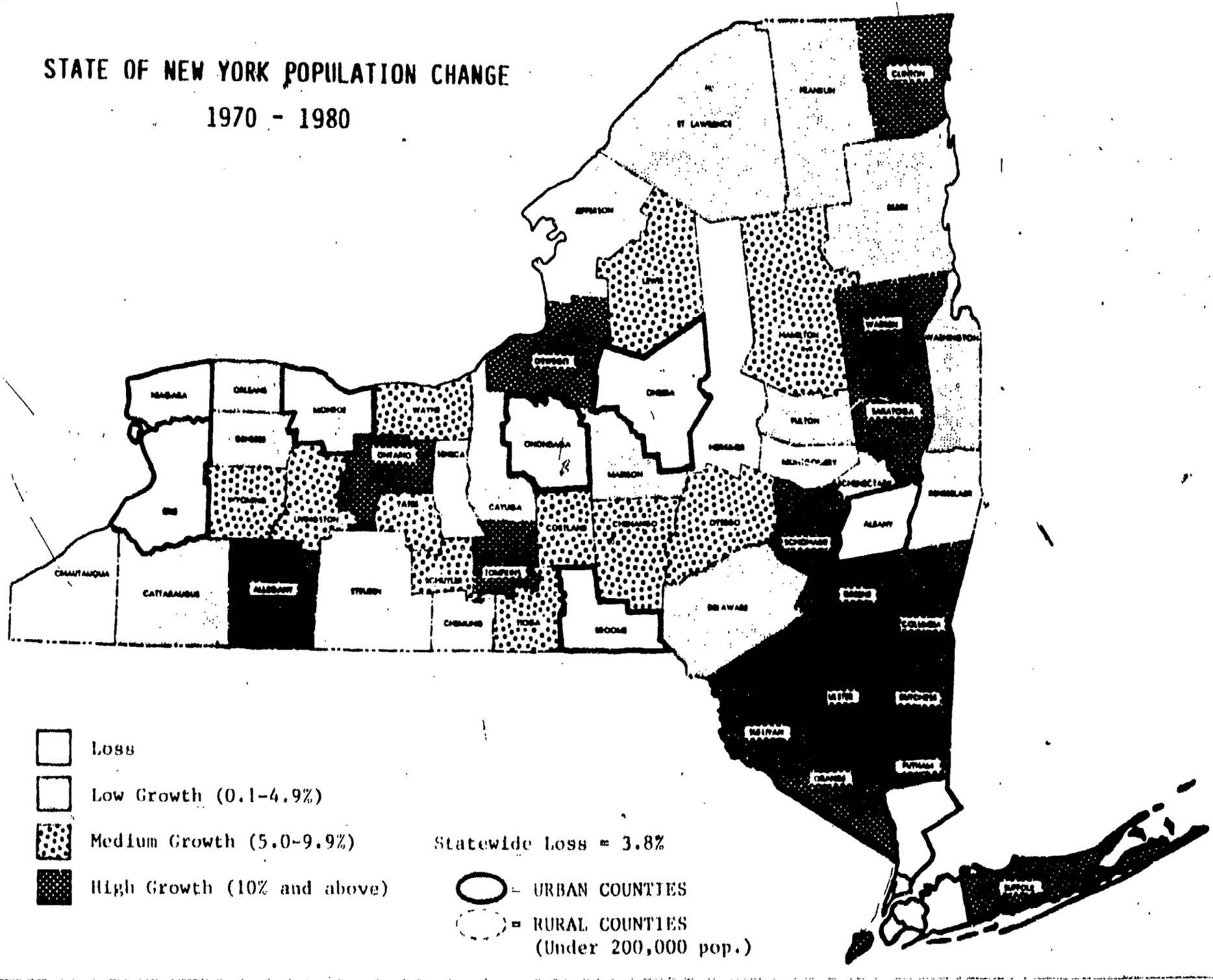
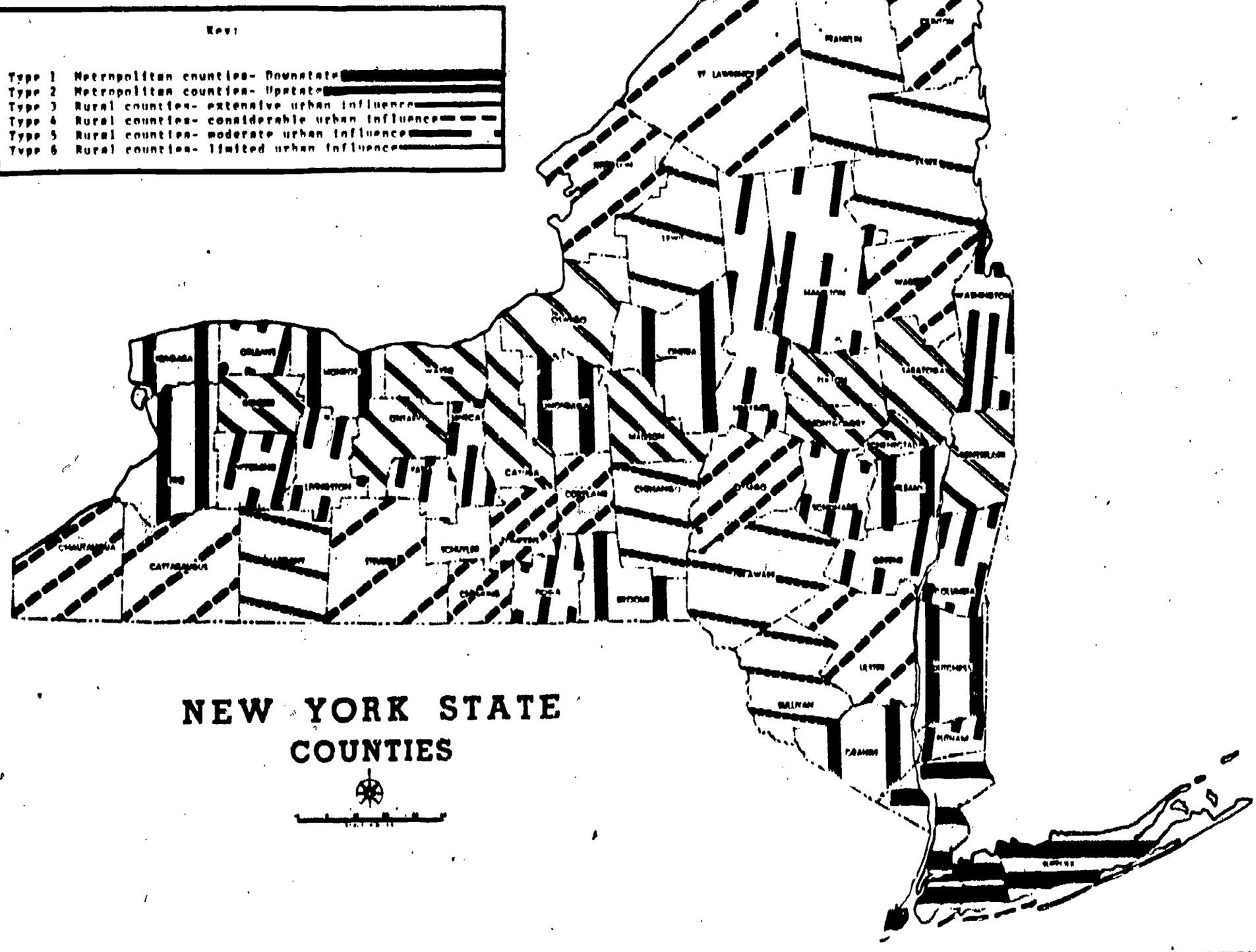
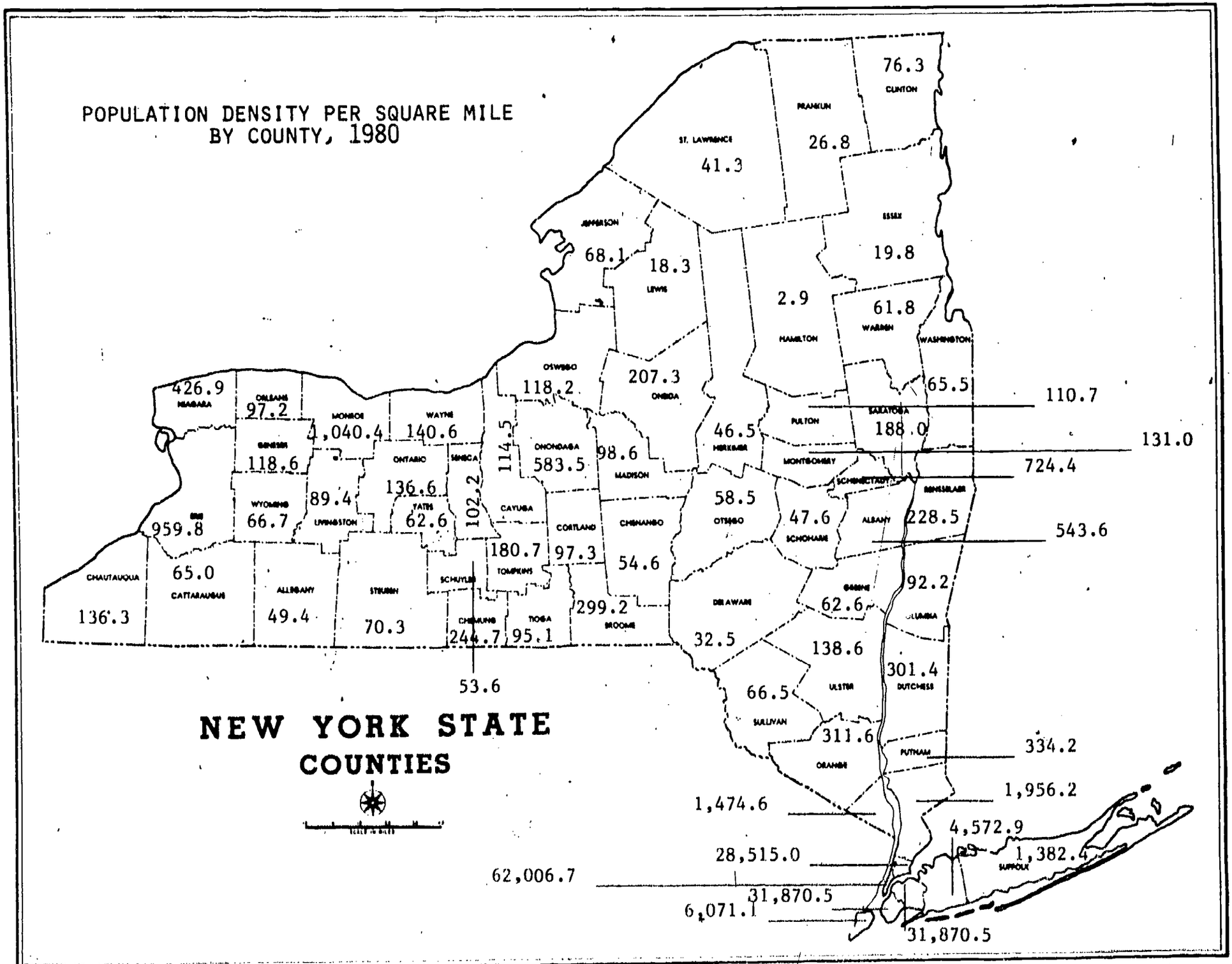
APPENDIX



Source: U.S. Bureau of the Census, 1980 Census of Population and Housing.




POPULATION DENSITY PER SQUARE MILE
BY COUNTY, 1980
76.3
CLINTON
FRANKLIN
26.8
ST. LAWRENCE
41.3
ESSEX
19.8
JEFFERSON
68.1
18.3
LEWIS
2.9
HAMILTON
61.8
WARREN
WASHINGTON
65.5
110.7
SARATOGA
188.0
131.0
724.4
207.3
ONEIDA
OSWEGO
118.2
46.5
HERKIMER
FULTON
MONTGOMERY
SCHENECTADY
RENSSELAER
228.5
543.6
ALBANY
SCHOHARIE
47.6
58.5
OTSEGO
98.6
MADISON
ONONDAGA
583.5
114.5
102.2
426.9
NIAGARA
ORLEANS
97.2
GENESEE
118.6
MONROE
1,040.4
WAYNE
140.6
ONTARIO
136.6
SENECA
62.6
YATES
89.4
WYOMING
66.7
LIVINGSTON
959.8
CAYUGA
180.7
TOMPKINS
CORTLAND
97.3
CHENANGO
54.6
CHAUTAUQUA
136.3
65.0
CATTARAUGUS
ALLEGANY
49.4
STEUBEN
70.3
SCHUYLER
CHEMUNG
244.7
TIOGA
95.1
299.2
BROOME
DELAWARE
32.5
GREENE
62.6
92.2
COLUMBIA
138.6
ULSTER
301.4
DUTCHESS
66.5
SULLIVAN
311.6
ORANGE
PUTNAM
334.2
1,956.2
1,474.6
4,572.9
28,515.0
1,382.4
SUFFOLK
62,006.7
31,870.5
6,071.1
31,870.5
53.6
NEW YORK STATE
COUNTIES

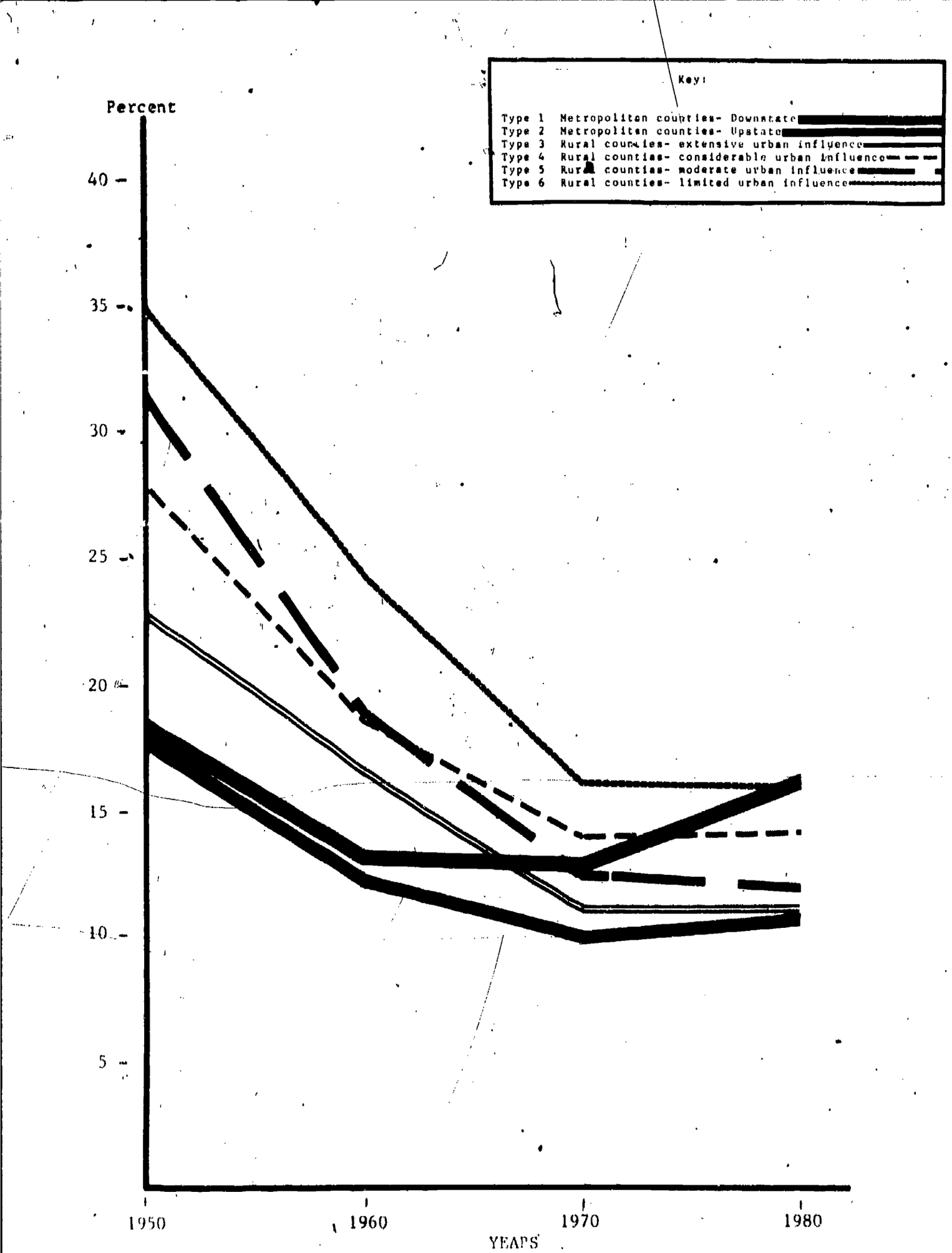


Figure 1. Percentage of Families in Poverty, by County Types, New York State, 1950-1980. Based on data from the United States Bureau of the Census.

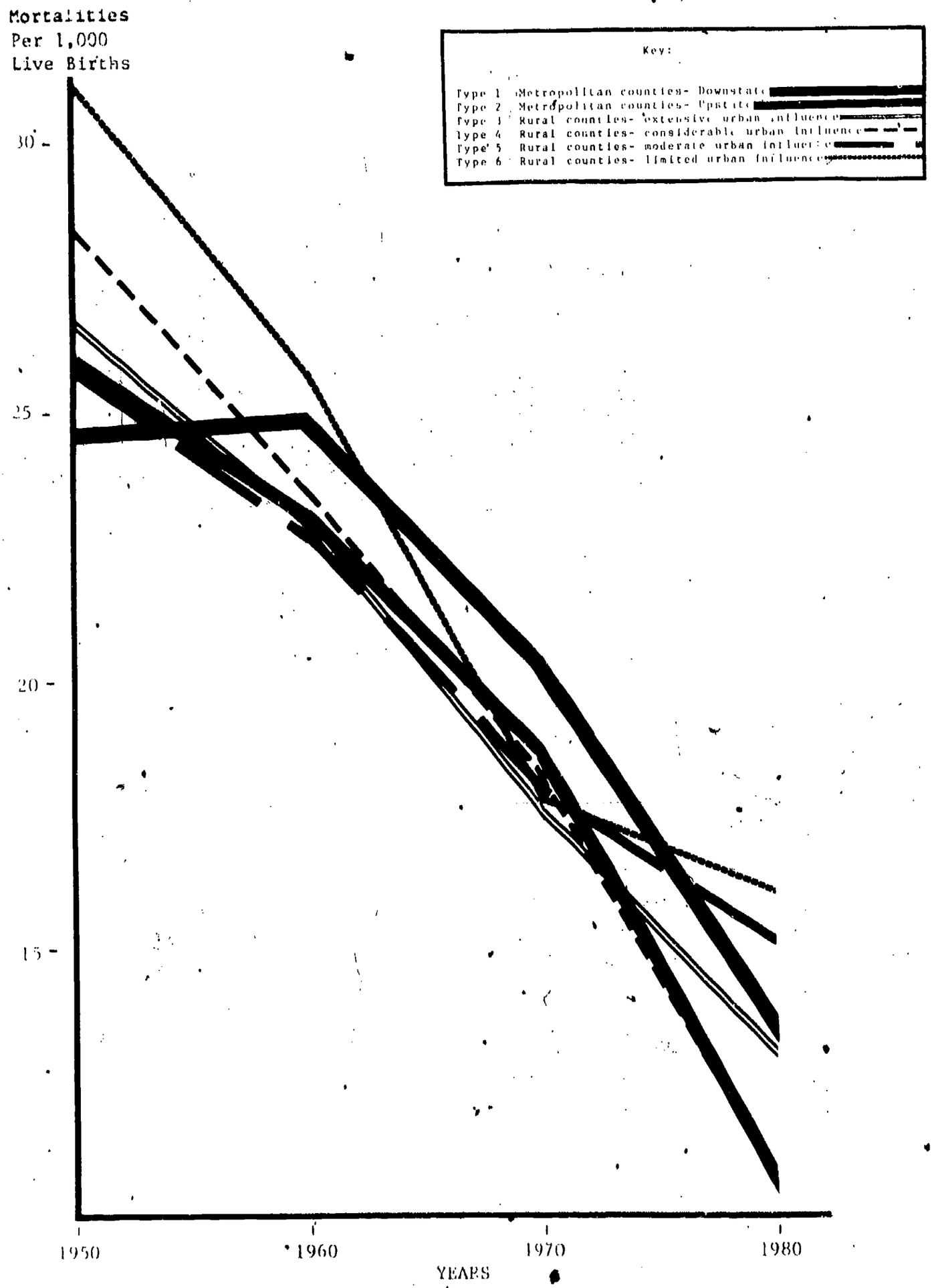


Figure 2. Infant Mortality (Three-Year Average) as a Percentage of 1,000 Live Births, by County Types, New York State, 1950-1980. Based on data from the United States Bureau of the Census.

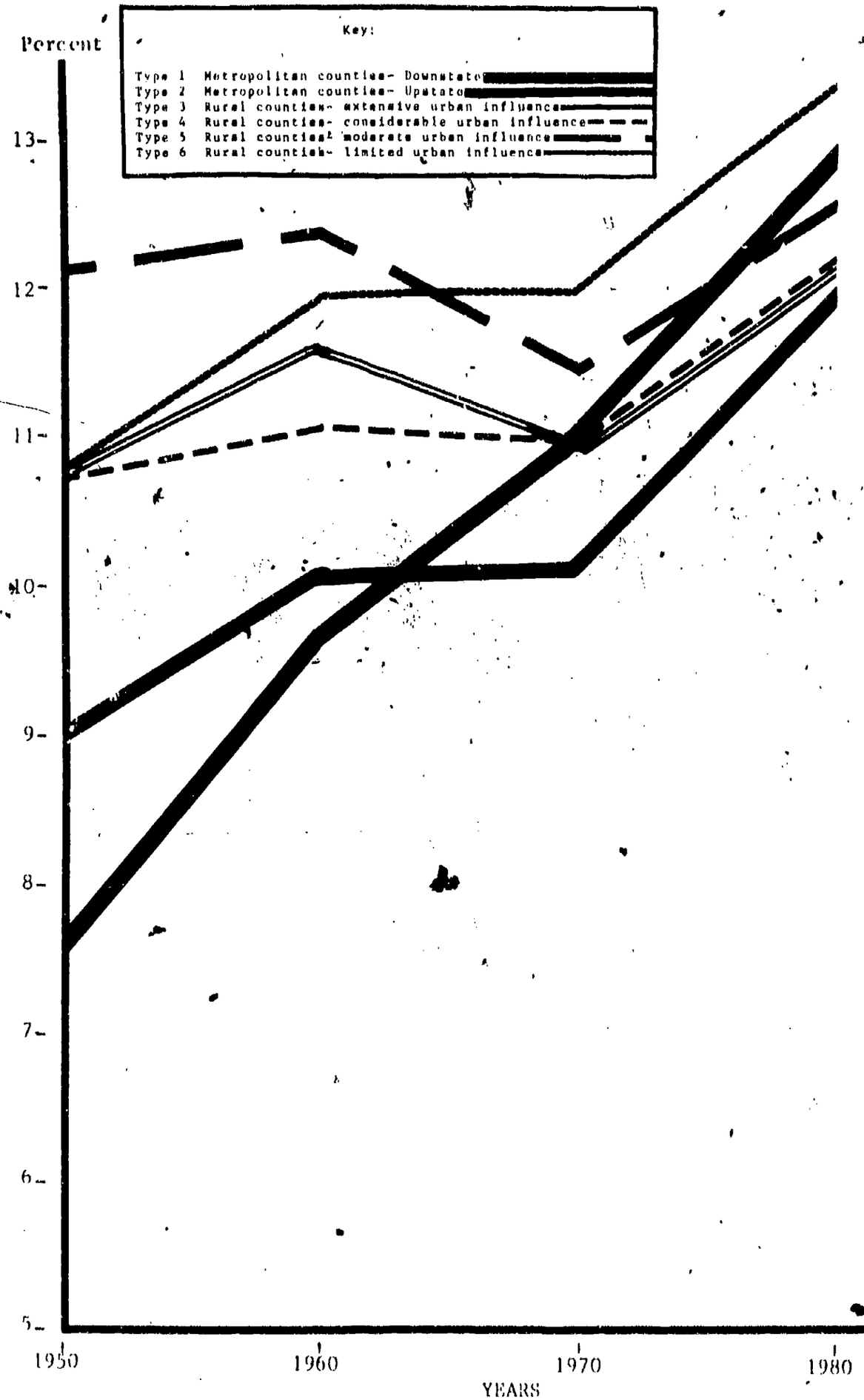
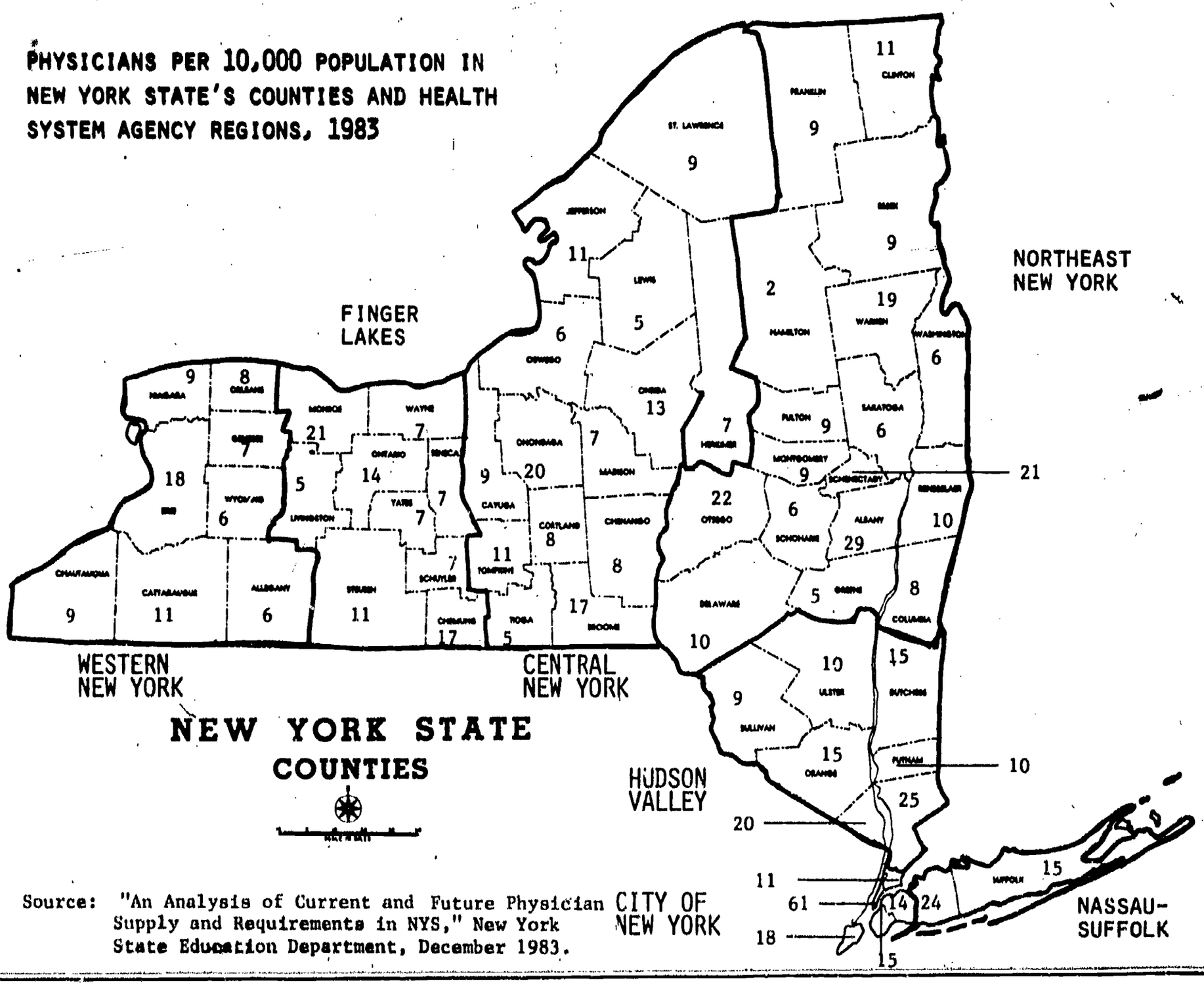


Figure 3. Percentage of Population 65 Years of Age and Over, by County Types, New York State, 1950-1980. Based on data from the United States Bureau of the Census.

PHYSICIANS PER 10,000 POPULATION IN NEW YORK STATE'S COUNTIES AND HEALTH SYSTEM AGENCY REGIONS, 1983



Source: "An Analysis of Current and Future Physician Supply and Requirements in NYS," New York State Education Department, December 1983.

NUMBER OF REGISTERED NURSES (R.N.'S) AND LICENSED PRACTICAL NURSES (L.P.N.s) PER 10,000 POPULATION IN NEW YORK STATE BY COUNTY

Rural Counties	1970 Population	1980 Population	1970 R.N.s	1970 L.P.N.s	1980 R.N.s	1980 L.P.N.s
Allegany	46,458	51,742	54	26	73	40
Cattaraugus	81,666	85,867	108	46	94	54
Cayuga	77,439	79,894	97	45	94	60
Chautauqua	147,305	146,925	86	43	90	49
Chemung	101,537	97,656	157	22	133	38
Chenango	46,368	49,344	67	30	66	34
Clinton	72,934	80,750	97	25	84	37
Columbia	51,519	59,487	109	33	108	31
Cortland	45,894	48,820	71	35	58	45
Delaware	44,718	46,931	65	35	62	53
Essex	34,631	36,176	94	38	85	47
Franklin	42,931	44,929	91	40	89	55
Fulton	52,637	55,153	89	26	84	36
Genesee	58,722	59,400	78	33	99	47
Green	33,136	40,861	85	29	76	41
Hamilton	4,714	5,034	104	19	111	32
Herkimer	67,407	66,714	78	28	82	49
Jefferson	88,508	88,151	114	45	113	71
Lewis	23,644	25,035	72	41	83	98
Livingston	54,041	57,006	87	32	96	41
Madison	62,864	65,150	67	25	75	48
Montgomery	55,883	53,439	89	30	91	46
Ontario	78,849	88,909	110	49	110	59
Orleans	37,305	38,496	36	20	51	48
Oswego	100,897	113,901	60	34	53	55
Otsego	56,181	59,075	88	38	89	67
Putnam	56,696	77,193	73	23	100	50
Rensselaer	152,510	151,966	91	29	103	54
Saratoga	121,764	153,759	84	32	102	50
Schenectady	161,078	149,946	97	39	113	68
Schoharie	24,750	29,710	54	25	53	42
Schuyler	16,737	17,686	70	33	83	42
Sececa	35,083	33,733	107	52	99	58
St. Lawrence	112,309	114,254	90	29	95	47
Steuben	99,546	99,135	95	24	102	50
Sullivan	52,580	65,155	66	27	87	36
Tioga	46,513	49,812	68	17	83	33
Tompkins	77,064	87,085	73	27	65	34
Ulster	141,241	158,158	96	22	94	35
Warren	49,402	54,854	106	40	112	45
Washington	52,725	54,795	72	35	77	48
Wayne	75,404	85,230	66	37	77	53
Wyoming	37,688	39,895	85	22	82	43
Yates	19,831	21,459	75	37	90	46
Metropolitan Counties						
Albany	286,742	285,909	93	25	116	47
Bronx	1,471,701	1,169,115	36	26	59	35
Broome	221,815	213,648	114	32	124	44
Dutchess	222,295	245,055	109	26	126	37
Erie	1,113,491	1,015,472	77	24	96	42
Kings	2,602,012	2,230,936	36	21	54	26
Monroe	711,917	702,238	88	26	99	37
Nassau	1,428,838	1,321,582	66	14	94	31
New York	1,539,233	1,427,533	82	27	78	21
Niagra	235,720	227,101	72	31	90	52
Onelda	273,070	253,466	106	36	120	64
Onondaga	472,835	463,324	92	24	103	49
Orange	221,657	259,603	87	26	98	33
Queens	1,987,174	1,891,325	50	20	66	28
Richmond	295,443	352,121	67	26	99	39
Rockland	229,903	259,530	75	17	131	37
Suffolk	1,127,030	1,284,231	69	20	87	36
Westchester	894,406	866,599	76	24	97	39
SUMMARY:						
New York State	18,241,391	17,557,458	68	24	84	36
Rural Counties	2,906,109	3,088,670	87	33	91	49
Metropolitan Counties	15,335,282	14,468,788	64	23	83	34

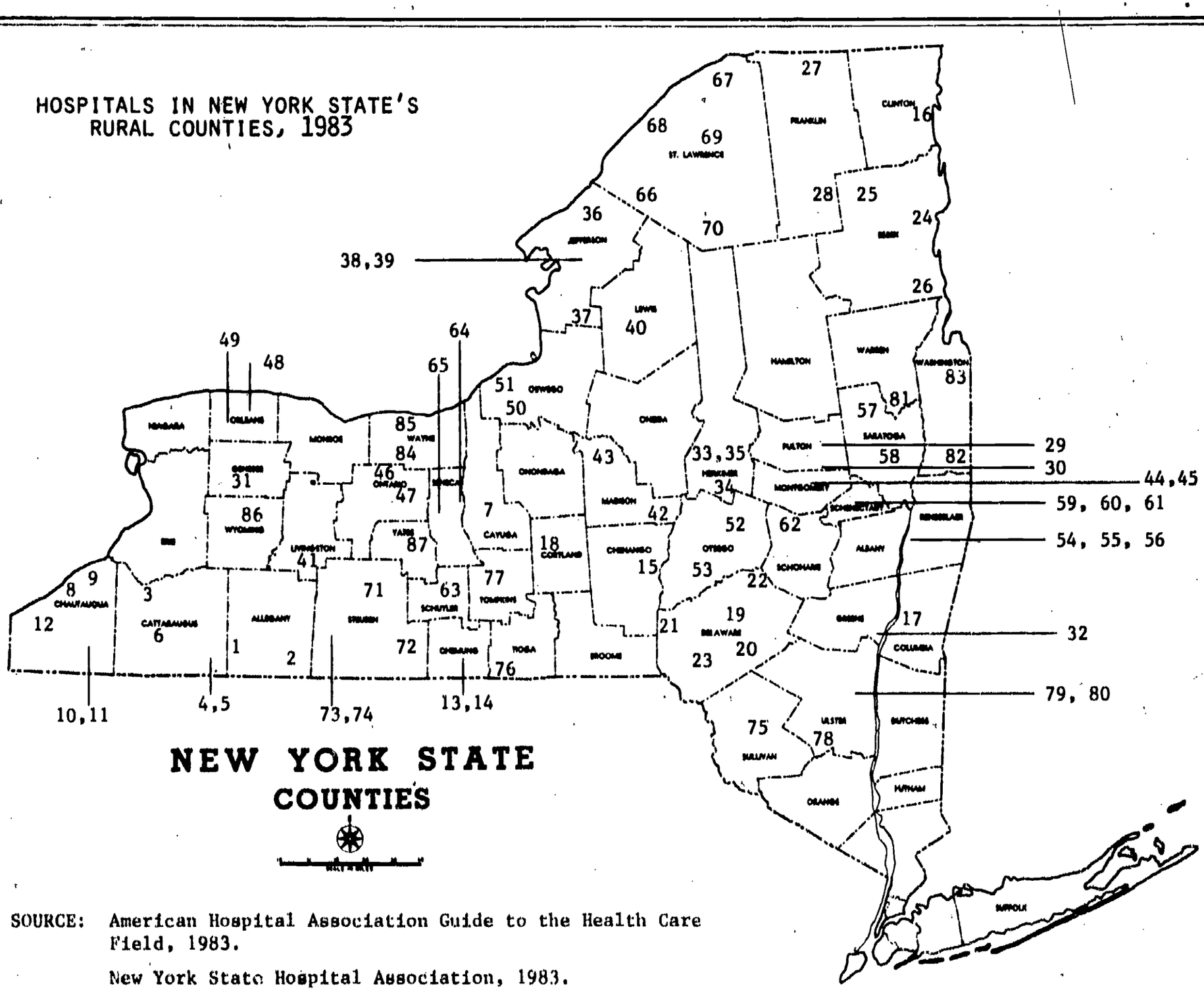
SOURCE: "Are Nurses in Short Supply? A New York State Perspective" Report of the Task Force on Nursing Personnel, New York State Health Advisory Council, January, 1981.

HOSPITALS IN NEW YORK STATE'S RURAL COUNTIES, 1983 (SEE MAP)

Name of Facility	Location
1. Cuba Memorial Hospital	Cuba
2. Memorial Hospital of William F. and Gertrude F. Jones	Wellsville
3. Tri-County Memorial Hospital	Gowanda
4. Olean General Hospital	Olean
5. St. Francis Hospital	Olean
6. Salamanca District Hospital	Salamanca
7. Auburn Memorial Hospital	Auburn
8. Brooks Memorial Hospital	Dunkirk
9. Lake Shore Hospital	Irving
10. Jamestown General Hospital	Jamestown
11. Woman's Christian Association Hospital	Jamestown
12. Westfield Memorial Hospital	Westfield
13. Arnot-Ogden Memorial Hospital	Elmira
14. St. Joseph's Hospital	Elmira
15. Chenango Memorial Hospital	Norwich
16. Champlain Valley Physicians Hospital Medical Center	Plattsburgh
17. Columbia Memorial Hospital	Hudson
18. Cortland Memorial Hospital	Cortland
19. A. Lindsay and Olive B. O'Connor Hospital	Delhi
20. Margaretville Memorial Hospital	Margaretville
21. The Hospital	Sidney
22. Community Hospital	Stamford
23. Delaware Valley Hospital	Walton
24. Elizabethtown Community Hospital	Elizabethtown
25. Placid Memorial Hospital	Lake Placid
26. Moses Ludington Hospital	Ticonderoga
27. Alice Hyde Hospital Association	Malone
28. General Hospital of Saranac Lake	Saranac Lake
29. Nathan Littauer Hospital	Gloversville
30. Johnstown Hospital	Johnstown
31. Genesee Memorial Hospital	Batavia
32. Memorial Hospital and Nursing Home of Greene County	Catskill
33. Herkimer Memorial Hospital	Herkimer
34. Mohawk Valley General Hospital	Ilion
35. Little Falls Hospital	Little Falls
36. E.J. Noble Hospital of Alexandria Bay	Alexandria Bay
37. Carthage Area Hospital	Carthage
38. House of the Good Samaritan	Watertown
39. Mercy Hospital of Watertown	Watertown
40. Lewis County General Hospital	Lowville
41. Nicholas H. Noyes Memorial Hospital	Danville
42. Community Memorial Hospital	Hamilton
43. Oneida City Hospital	Oneida
44. Amsterdam Memorial Hospital	Amsterdam
45. St. Mary's Hospital	Amsterdam
46. Clifton Springs Hospital and Clinic	Clifton Springs
47. Geneva General Hospital	Geneva

Name of Facility	Location
48. Arnold Gregory Memorial Hospital and Skilled Nursing Facilities	Albion
49. Medina Memorial Hospital	Medina
50. Albert Lindley Lee Memorial Hospital	Fulton
51. Oswego Hospital	Oswego
52. Mary Imogene Bassett Hospital and Clinics	Cooperstown
53. Aurelia Osborn Fox Memorial Hospital	Oneonta
54. Leonard Hospital	Troy
55. Samaritan Hospital	Troy
56. St. Mary's Hospital	Troy
57. Adirondack Regional Hospital	Corinth
58. Saratoga Hospital	Saratoga Springs
59. Bellevue Maternity Hospital	Schenectady
60. Ellis Hospital	Schenectady
61. St. Clare's Hospital	Schenectady
62. Community Hospital of Schoharie County	Cobleskill
63. Schuyler Hospital	Moutour Falls
64. Seneca Falls Hospital	Seneca Falls
65. Taylor-Brown Memorial Hospital	Waterloo
66. E.J. Noble Hospital of Gouverneur	Gouverneur
67. Massena Memorial Hospital	Massena
68. A. Barton Hepburn Hospital	Ogdensburg
69. Canton-Potsdam Hospital	Potsdam
70. Clifton-Fine Hospital	Star Lake
71. Ira Davenport Memorial Hospital	Bath
72. Corning Hospital	Corning
73. Bethesda Community Hospital	Hornell
74. St. James Mercy Hospital	Hornell
75. Community General Hospital of Sullivan County	Harris
76. Tioga General Hospital	Waverly
77. Tompkins Community Hospital	Ithaca
78. Ellenville Community Hospital	Ellenville
79. Benedictine Hospital	Kingston
80. Kingston Hospital	Kingston
81. Glens Falls Hospital	Glens Falls
82. Mary McClelan Hospital	Cambridge
83. Emma Laing Stevens Hospital	Granville
84. Newark-Wayne Community Hospital	Newark
85. Myers Community Hospital	Sodus
86. Wyoming County Community Hospital	Warsaw
87. Soldiers and Sailors Memorial Hospital	Penn Yan

SOURCE: American Hospital Association Guide to the Health Care Field, 1983.



SOURCE: American Hospital Association Guide to the Health Care Field, 1983.

New York State Hospital Association, 1983.

HOSPITALS IN NEW YORK STATE'S RURAL COUNTIES
1983

Rural Counties	Number of Beds: Hospital	Number of Beds: Nursing Home Type Units	Hospital Beds Per 10,000 Population	Obstetrics Available	Total Expenditures (Thous. of Dollars	Total Number Personnel
Allegany	157	30	30	X	$11,455	481
Cattaraugus	390	-	45	X	25,094	1,055
Cayuga	294	-	37	X	10,456	752
Chautauqua	672	80	46	X	49,184	1,925
Chemung	527	71	54	X	62,826	2,224
Chenango	100	41	20	X	8,936	342
Clinton	376	54	47	X	28,084	1,026
Columbia	170	-	28	X	14,118	560
Cortland	177	-	36	X	14,101	533
Delaware	173	95	37	X	16,390	690
Essex	113	-	31	X	6,222(a)	306
Franklin	180	75	40	X	13,632	601
Fulton	177	-	32	X	17,085	667
Genesee	125	-	21	X	8,153	345
Greene	114	120	28	X	11,263	432
Hamilton(b)	-	-	-	-	-	-
Herkimer	269	34	40	X	13,493(a)	787
Jefferson	570	240	65	X	46,559	1,959
Lewis	76	120	78	X	8,966	400
Livingston	85	-	15	X	6,642	259
Madison	151	148	23	X	14,664	543
Montgomery	273	61	51	X	23,179	823
Ontario	270	82	30	X	29,864	1,114
Orleans	119	60	31	X	9,208	416
Oswego	269	-	24	X	6,117(a)	815
Otsego(d)	315	130	53	X	40,458	1,803
Putnam(b)	-	-	-	-	-	-
Rensselaer	654	19	43	X	40,943(a)	2,183
Saratoga	186	76	12	X	18,248	803
Schenectady	814	-	54	X	83,488	2,807
Schoharie	70	-	23	X	5,903	206
Schuyler	52	40	29	X	6,619	265
Seneca	116	33	34	-	6,534	279
St. Lawrence	389	29	34	X	29,117	1,206
Steuben	358	120	36	X	34,050	1,523
Sullivan	281	40	43	X	25,372	826
Tioga	67	80	13	-	(c)	222
Tompkins	191	-	22	X	18,672	677
Ulster	532	-	34	X	25,544	1,470
Warren	440	-	80	X	38,505	1,463
Washington	99	39	18	X	8,658	353
Wayne	214	44	25	X	17,376	678
Wyoming	108	72	27	X	10,737	398
Yates	62	24	29	-	4,456	189
SUMMARY:						
	10,895	1,937	35		$870,371	36,356

(a) One hospital did not report total expenditures and is not included here.
(b) No hospital in this county.
(c) The lone hospital in Tioga county did not report total expenditures.
(d) Otsego County figures include a teaching and research hospital in Cooperstown.

SOURCE: American Hospital Association Guide to the Health Care Field, 1983.

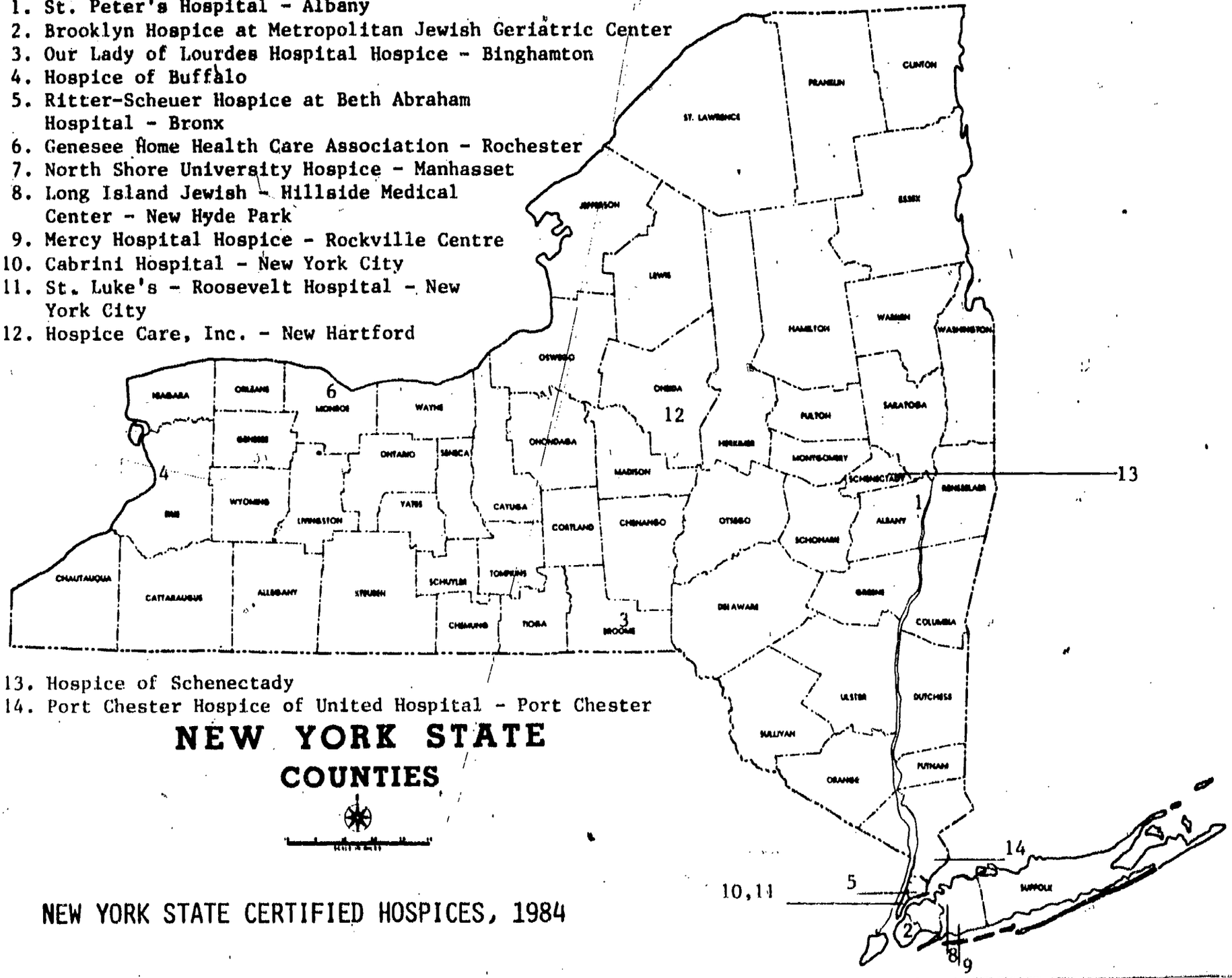
HOSPITALS CLOSED IN RURAL COUNTIES 1973 - 1983

Name of Facility	Location	County	Number of Beds	Effective Date
E.J. Barber Hospital	Lyons	Wayne	25	11/01/73
Lyons Community Hospital	Lyons	Wayne	29	11/01/73
E.J. Noble Hospital	Canton	St. Lawrence	65	11/13/74
Will Rogers Hospital	North Elba	Essex	64	12/31/75
Mercy Hospital	Auburn	Cayuga	60	7/31/77
Community Hospital of Sullivan County - Liberty Division*	Liberty	Sullivan	76	7/09/77
Community Hospital of Sullivan County - Monticello Division*	Monticello	Sullivan	83	7/09/77
Liberty Loomis Hospital	Liberty	Sullivan	40	7/13/77
Keene Valley Hospital	Keene	Essex	18	1/31/78
Benedict Memorial Hospital	Ballston Spa	Saratoga	33	9/30/80
Read Memorial Hospital	Hancock	Delaware	31	4/30/81
Hamilton Avenue Hospital	Monticello	Sullivan	68	6/11/82

*Merged to form Community General Hospital of Sullivan County, located in Harris, New York.

Source: New York State Hospital Association

1. St. Peter's Hospital - Albany
2. Brooklyn Hospice at Metropolitan Jewish Geriatric Center
3. Our Lady of Lourdes Hospital Hospice - Binghamton
4. Hospice of Buffalo
5. Ritter-Scheuer Hospice at Beth Abraham Hospital - Bronx
6. Genesee Home Health Care Association - Rochester
7. North Shore University Hospice - Manhasset
8. Long Island Jewish - Hillside Medical Center - New Hyde Park
9. Mercy Hospital Hospice - Rockville Centre
10. Cabrini Hospital - New York City
11. St. Luke's - Roosevelt Hospital - New York City
12. Hospice Care, Inc. - New Hartford

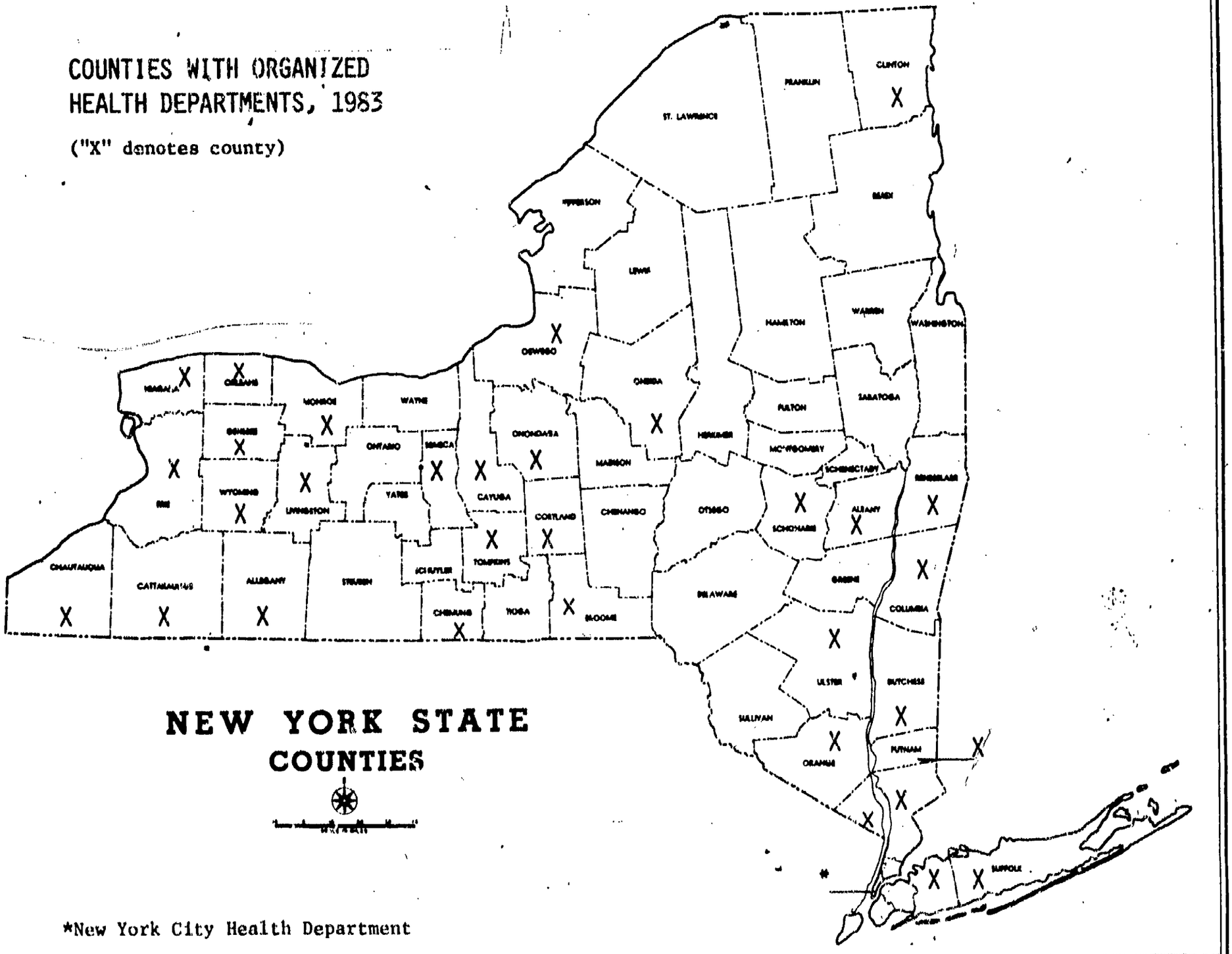


13. Hospice of Schenectady
14. Port Chester Hospice of United Hospital - Port Chester

NEW YORK STATE

COUNTIES

NEW YORK STATE CERTIFIED HOSPICES, 1984


COUNTIES WITH ORGANIZED
HEALTH DEPARTMENTS, 1983
("X" denotes county)
NEW YORK STATE
COUNTIES
*New York City Health Department