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I. ESSAY

Evaluating Rural Hospital Consortia

by Jon B. Christianson, Ira S. Moscovice, Judy Johnson, John Kralewski, and Colleen Grogan

More and more, the popular press discusses rural hospitals as though they were an “endangered species,” with the implication that the forces leading to their extinction are inexorable. Indeed, the problems facing these institutions do seem at times to be overwhelming.\(^1\) During the 1980s, the declining economy of many rural areas led increasing numbers of young adults to migrate to urban areas. The remaining population served by rural hospitals is becoming poorer, older, and increasingly likely to be covered by public insurance programs. Because of the relatively high proportion of rural hospital patients who are elderly, rural hospitals are particularly vulnerable to Medicare payment policies. Rural advocates argue that current policies are insensitive to the special problems of small hospitals, pointing to reports of widespread financial losses and an increasing number of hospital closures concentrated among facilities with fewer than fifty beds.\(^2\) Some sources predict that as many as 600 rural hospitals could close over the next few years.\(^3\)

The problems of rural hospitals have generated a sympathetic response from the media and some members of Congress.\(^4\) Both the 99th and the 100th Congress passed legislation to modify the way in which rural hospitals are paid under Medicare’s prospective payment system (PPS). In the 100th Congress, the National Rural Health Care Act of 1988 was introduced by Rep. Edward Roybal (D-CA) with a wide-ranging agenda for changes in rural health care financing and delivery. Congress also legislated a “transition grants” program, under the sponsorship of Sen. David Durenberger (R-MN). This program, administered

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through the Health Care Financing Administration (HCFA), provides small grants to rural hospitals to diversify services, convert acute care beds to other uses, and engage in other similar activities. In addition, the Department of Health and Human Services (HHS) has created an Office of Rural Health Policy to coordinate public- and private-sector initiatives on rural health care. Clearly, rural health care delivery, and particularly the viability of rural hospitals, has emerged once again as a high-profile issue for federal health policymakers, although no coherent overall rural health policy has yet been articulated.

Stimulated in part by government and private foundation grant programs, rural hospitals have increasingly sought to address their problems through collective action. Many of these facilities have affiliated with a multihospital system. The American Hospital Association (AHA) reports that about one-third of rural community hospitals are owned, leased, or contract-managed by multihospital systems, and that system involvement is heaviest in regions where investor-owned systems are most prevalent (South Atlantic, Mountain, and Pacific). However, this trend appears to have weakened, possibly because of financial losses incurred by these systems coupled with concerns on the part of rural communities that system affiliation can result in a loss of hospital autonomy and reduced hospital sensitivity to local needs. In contrast, rural hospital alliances, or consortia, seem to be gaining in popularity among rural hospitals as a means of obtaining the benefits of collective action, while maintaining a greater degree of local control over hospital decision making. In this essay, we describe rural hospital consortia in the United States and discuss the factors that appear to facilitate or impede their development, using data collected as part of an ongoing evaluation of The Robert Wood Johnson Foundation’s Hospital-Based Rural Health Care (HBRHC) program.

An Overview Of Rural Hospital Consortia

While the level of formality of consortium arrangements varies, the primary purpose of all rural hospital consortia is to provide an administrative framework for developing joint activities among member institutions. As the Senate’s Special Committee on Aging (1989) has observed, relatively little is known about the number, structure, and activities of rural hospital consortia or the developmental problems that they face. A 1986 survey conducted by National Health Advisors found nine rural hospital alliances ranging in size from four to twenty-five hospitals. More recently, a staff report to the Senate’s Special Committee on Aging speculated that as many as a quarter of rural hospitals (approximately
650) participate in hospital consortia.  

**Methods.** In December 1988, we initiated an effort to identify and survey all rural hospital consortia in the United States. We began with a list of 180 consortium applicants to the HBRHC program and added to this number through a phone survey of representatives of each of the fifty state hospital associations. We identified 269 potential rural hospital consortia in this manner. We completed telephone interviews with representatives from 266 of these organizations, resulting in a list of 127 groups of rural hospitals that met our loose definition of a consortium: any group of rural hospitals (or rural and urban hospitals) that meet or work together for specific purposes and have specific membership criteria.

**Results.** The average number of rural hospitals in these consortia was 12.7, with a median participation of nine. If this represented an unduplicated count, it would suggest that 1,600 hospitals nationwide belong to consortia. However, since many rural hospitals participate in more than one consortium, the total number of hospitals participating in consortia is approximately 1,000, or slightly less than half of all U.S. rural hospitals. Clearly, rural hospital consortia have the potential to play a significant role in health care delivery in rural areas.

It appears that rural hospital consortia are a relatively recent phenomenon, since 59 percent of the consortia we identified were three years old or younger in December 1988, while only 14 percent had existed for longer than ten years. Twenty-eight percent of the consortia had nonhospital members, and slightly over half listed a hospital located in a metropolitan statistical area as a member.

**Activities.** Typically, hospitals in rural consortia retain the option of participating, or not participating, in each consortium activity. The common thread among all such activities is that voluntary cooperation among rural hospitals can yield benefits unavailable to an individual hospital acting alone. For example, while a single rural hospital may not have adequate numbers of patients or resources to purchase specialized equipment, a group of rural hospitals may be able to do so in a cost-effective manner. Thus, a consortium of rural hospitals in the Midwest has purchased magnetic resonance imaging (MRI) equipment jointly. Sharing services of this type can benefit rural hospitals financially by reducing the likelihood that rural residents will travel to urban centers for specialized diagnostic care. It also, of course, improves access to services in rural areas.

Joint physician and staff recruitment can be carried out through consortia, since a group of hospitals often can negotiate a more favorable contractual arrangement with a recruiting firm than can a single rural hospital. Consortium members can share advertising costs for allied
health personnel and nurses, allowing broader coverage in national journals. In some consortia, shared staff arrangements for allied health and nursing personnel have evolved to address fluctuations in patient census or the need for flexible part-time staff.

Consortia can also facilitate the sharing of costs for marketing surveys or community relations campaigns for their members. And, group efforts to improve quality in rural hospitals are now occurring through consortia. Standardized credential review processes and the sharing of a full-time quality assurance coordinator often result from these efforts. Many other kinds of activities are possible under a consortium framework, including management and financial consultation, acute care bed conversions, the development of primary or specialty clinics, lobbying on legislative issues, and regional planning. In our survey, we found that the average consortium was involved in six different types of activities. Four out of five consortia had educational programs for physicians or hospital personnel, and four of five had shared service programs. Two-thirds of rural hospital consortia conducted legislative liaison activities. The least common activities arguably were the ones requiring the highest level of cooperation and trust among participating hospitals: acute care bed conversions and quality assurance. Only one of five consortia reported acute care bed conversion projects, and two of five had joint quality assurance or credentialing efforts.

Participants In The HBRHC Program

If participation in a hospital consortium proves to be an attractive way for rural hospitals to enhance their financial viability and the quality of the services they offer to their communities, then it will be important for policymakers and hospital administrators to understand the factors that can influence consortium development and implementation. To identify these factors, we conducted structured interviews with consortium directors and hospital administrators at the thirteen HBRHC program sites, approximately four to nine months after they had first received grant funds from The Robert Wood Johnson Foundation.

Grants process. The consortia in the HBRHC program were selected from 180 applications submitted by groups of hospitals and other health care organizations in response to a program solicitation by the foundation. Fourteen consortia were chosen to receive funding of approximately $150,000 per year, with a progress review to occur at the end of two years. The foundation offered a maximum of four years of support, along with access to loan funds not to exceed $500,000 per consortium. One of the selected consortia withdrew from the program early in its first year.
because it was unable to maintain support among its member hospitals for its only proposed program—a rural health maintenance organization (HMO).

Characteristics. There was considerable variation in regional environments and organizational characteristics among the remaining thirteen consortia. The degree of prior collaboration among hospitals ranged from little or no previous cooperative activities or meetings in some consortia to a highly formalized consortium that had been in existence for ten years. The consortia were administered through state hospital associations, state planning agencies, tertiary care centers, and freestanding consortium organizations. In most cases, the consortium’s governing board was composed of all consortium members, while, in a few cases, the board was composed of a smaller number of appointed members. All consortia had a designated director, although the person designated sometimes had other duties as well. The number of additional consortium staff, beyond the director, ranged from none to over forty.

Environmental and demographic characteristics indicate a great deal of diversity among the thirteen consortium sites. The population of their market areas ranged from 44,000 persons in northern Montana to nearly one million persons in South Carolina and in southern Maine. The smallest geographic area included within a consortium boundary was 3,500 square miles (northeastern New York), while the largest was 90,000 square miles (Nevada). Population density was lowest in Nevada, at 1.1 persons per square mile, and highest in western New York, at 119 persons per square mile. The percentage of the population age sixty-five and over ranged from 8.9 percent in South Carolina to 15.4 percent in Missouri, while the percentage of area population living in poverty ranged from 10.6 percent in western New York to 25.3 percent in Alabama. Physician shortages appeared particularly acute in Nevada (sixty-one physicians per 100,000 residents) and Montana (sixty-six per 100,000 residents). Northern Maine, southern Maine, and northeastern New York were the consortium areas with the greatest number of physicians per capita, but they were still below the national average of about 180 patient care physicians per 100,000 population.

The HBRHC consortia proposed to pursue a broad range of activities (Exhibit 1). Eight consortia intended to develop shared-services programs of some type, while seven planned joint professional recruitment activities. Seven others hoped to develop primary care or specialty clinics through the cooperative efforts of participating hospitals. At the other extreme, only two consortia planned to develop quality assurance programs.

Despite the purposeful nature of the selection process for HBRHC
### Exhibit 1
Summary Of Rural Hospital Consortium Activities, The Robert Wood Johnson Foundation’s Hospital-Based Rural Health Care Program, 1988

<table>
<thead>
<tr>
<th>Activities</th>
<th>AL</th>
<th>MO</th>
<th>MS</th>
<th>MT</th>
<th>NC</th>
<th>NME</th>
<th>NNY</th>
<th>NV</th>
<th>SC</th>
<th>SME</th>
<th>TX</th>
<th>WI</th>
<th>WNY</th>
</tr>
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<tbody>
<tr>
<td>Shared services</td>
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<td>●</td>
<td>●</td>
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<tr>
<td>Acute care bed conversions</td>
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<td>●</td>
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<td>Quality assurance</td>
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<td>Primary/specialty clinics</td>
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<td>Marketing/public relations</td>
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<td>Financial management</td>
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<tr>
<td>Professional recruitment/development</td>
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<tr>
<td>Regional affiliation</td>
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<td>Regional strategic planning</td>
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Consortia, these consortia were similar in many respects to other rural hospital consortia. For example, our survey data indicate that the average membership size (including nonrural hospitals and other organizations) of program and nonprogram consortia was almost identical (14.8 versus 15.1). In addition, the two pursued the same types of activities. However, while program consortia were representative of other rural hospital consortia in important respects, there were also some differences. For example, while most HBRHC consortia were located east of the Mississippi, non-HBRHC consortia were located throughout the country (in forty states) with the highest concentrations in the North Central, Great Lakes, and Western regions. Non-HBRHC consortia were older on average than HBRHC consortia (six years versus three years), but HBRHC consortia were more likely to have a steering committee or board, paid
staff, and group funding, reflecting in part the structure imposed on them by participation in the foundation’s program. Among consortia that have a board, paid staff, and funding, HBRHC and non-HBRHC consortia were similar in size of board, number and type of paid staff, and types of funding sources.

Developmental Issues

Interview respondents at the HBRHC sites were asked to identify factors that they thought had facilitated or constrained development of their consortium. Also, in the course of answering more general questions about their roles in, and views of, consortium development, respondents quite frequently addressed these same issues. These interview responses were combined with regular operational reports submitted by the consortia and other data to construct an overall picture of factors influencing their development and early operations. To facilitate exposition and the development of qualitative hypotheses, we grouped these factors into three categories: (1) features of consortium environment; (2) availability of resources to the consortia, including administrative capacity; and (3) organizational structure and characteristics.

Environmental forces are conditions external to the consortium development process that can affect the process indirectly through their impact on the participating hospitals. For example, a recessionary economy can affect rural hospitals by reducing utilization and increasing bad debt, with a varied impact on consortium development. It would facilitate development if rural hospitals saw their deteriorating financial situation as reason to undertake joint activities. On the other hand, it could constrain development if it reduced the financial support and staff time that rural hospitals could make available to these activities. These possible impacts are not mutually exclusive; both could operate simultaneously in the same hospital consortium or, indeed, the same hospital.

The term “resources” refers to the funds available to carry out programmatic activities as well as availability of personnel, in adequate numbers and with appropriate expertise, to successfully carry out the proposed programs. These personnel could play a leadership role at the consortium or hospital administrative level, or be professionals actually involved in the delivery of services. It was expected that the primary effect of limited resources would be to constrain the growth of consortia. However, it also could be that resource limitations might force participating consortium hospitals to share personnel or set program priorities more effectively, and thereby increase the ability of consortia to achieve specific programmatic goals.
The structure and operating methods of organizations also can facilitate or impede developmental activities. Even relatively straightforward issues such as the effectiveness of communication among participants in the implementation process, the intellectual commitment of hospital administrators to the consortium, and the attitudes of hospital staff toward the staff of other hospitals can assume major significance at critical points in implementation. And, studies of implementation and innovation often highlight the key role that a program “champion” can play in facilitating implementation.

Environmental factors. Based on a cross-site analysis of interview responses, three environmental factors were perceived to be of greatest importance to the development of consortia: the loss of patients to urban providers, the condition (financial and physical) of the hospitals in the consortium, and the constraints imposed by state and federal regulations. In each case, however, the impact of these factors was seen as mixed; that is, in some ways they facilitated consortium development, while in others they constrained it. For instance, in six sites, at least one respondent identified the loss of patients to urban hospitals and clinics as creating incentives for hospitals to join in cooperative activities designed to reduce patient “leakage.” But, respondents at nine sites saw competition from urban centers as constraining implementation indirectly, by weakening rural hospitals financially and thereby limiting the resources they could devote to the consortium. At three sites, respondents perceived both influences to be in effect.

Responses regarding the effect of participating rural hospitals’ financial status and the condition of their physical plants were also mixed, but for somewhat different reasons. At five sites, these were seen as constraining factors. However, at nine sites, at least some rural hospital administrators saw the good condition of their physical plants and/or the financial stability of their institutions as contributing to successful consortium development. Similarly, at nine sites, the favorable reputation of rural hospitals in their communities was perceived to be a positive factor for implementation of consortium programs. Since all rural hospital administrators in HBRHC consortium hospitals were not interviewed, this may simply represent sampling bias. Or, it could mean that hospitals in poor financial condition, with inadequate physical plants, were less likely to be part of consortia chosen to participate in the HBRHC program. Those that were part of HBRHC consortia may have been reluctant to reveal concern about the impact of these limitations on consortium development. Even hospital administrators who felt that their institutions were financially stable expressed concerns about long run viability.
Respondents at eight sites believed state and federal regulations affected their activities in two different ways. At a general level, reimbursement restraints (particularly Medicare’s) and operating regulations were seen as detrimental to rural hospitals and, therefore, as indirect constraints to consortium development. More specifically, at several sites, respondents attempting bed conversions or diversification activities saw state regulations as barriers to achieving program objectives. It may be that the more complex such consortium activities are, the more likely they are to be influenced by regulatory programs. In four sites, however, respondents saw good relations with state officials as facilitating implementation of programs. As with the competitive threat of urban hospitals, respondents at three sites believed that onerous federal and state regulations had created incentives for rural hospitals to pool resources and make difficult collective choices.

Several other environmental factors were identified less frequently as constraining or facilitating consortium development. These include hospital/medical staff relations, economic conditions in the region, and public awareness of consortia created by local media.

Resource factors. Relative to environmental factors, respondents identified fewer resource-related issues as facilitating or constraining implementation. The resource-related factor that was identified at the most sites (twelve) as facilitating consortium development was the involvement of an external party, particularly at the consortium conceptualization stage. Third parties included health system agencies, urban hospitals, consulting firms, state offices of rural health, universities, and state hospital associations. In many cases, individuals associated with these organizations made their expertise available to consortium participants without cost. In a few instances, assistance was provided with the understanding that the organization and consortium would develop a long-term relationship once the consortium became operational. Respondents consistently identified the assistance of an external party as critical to consortium development.

Several other resource issues pertained to the difficulties of recruiting personnel to rural areas. At eight sites, respondents mentioned physician recruitment as a constraining factor both in general, as it related to the overall viability of their hospitals, and specifically, as it related to the ability of the consortium to implement its planned initiatives. Similarly, five sites identified the recruitment of nurses and other personnel to rural hospitals as a constraining factor. Respondents at four sites saw problems in recruiting consortium (as differentiated from hospital) staff as a constraint for consortium development and program implementation, while at four sites, turnover of administrators at participating hospitals
also was seen as hindering consortium development.

**Organizational factors.** Compared to environmental and resource-related factors, respondents identified a wider array of organizational factors as influencing consortium development and implementation. While most of these factors were present in four or fewer sites, there were two noteworthy exceptions. First, historical relationships among participating hospitals were seen as facilitating implementation at eleven sites and constraining it at six sites. The interview responses revealed that, in virtually every case, at least some participating consortium hospitals had experience in less-structured cooperative efforts before the consortium was formed, such as meetings to identify common interests with respect to state legislative initiatives. This facilitated consortium development since, in these cases, the rural hospital administrators had become comfortable with each other, gained a better understanding of common problems, and enjoyed some success in pursuing joint endeavors prior to creating a more formal consortium.

At about half the sites, previous relationships among rural hospitals were seen as impeding the development of a consortium. At these sites, some rural hospitals were perceived as still being in a “competitive mode” with each other. In most cases, however, this was believed to be breaking down in response to external pressures that created incentives for cooperation. In particular, the loss of patients to urban providers was viewed as a more salient, and certainly more widespread, threat than the loss of patients to neighboring rural institutions.

A second organizational factor that was frequently identified as affecting consortium development was the assumption of a leadership role by one of the participating rural hospitals. In almost all cases, as consortia moved from the developmental to the early operational phase, a leader emerged from the participating rural hospitals. Typically, this role was assumed by a relatively large rural facility that served as a rural referral center for some specialty services. This facility assumed leadership by virtue of the aggressiveness of its administrators and its ability to donate staff time and other resources to the development of consortium projects. However, this was viewed as a mixed blessing by many of the other hospital administrators in the consortium. While acknowledging that the lead hospital made valuable contributions to the implementation and early operations of the consortium, the other consortium participants sometimes distrusted the leader’s motivations. They believed that the lead hospital slanted consortium programs to benefit itself more than the consortium as a whole. At some sites, administrators of the lead hospital acknowledged that other administrators might hold this view and expressed concern about its potential effect on consortium operations.
Conclusions

**Issues for further investigation.** Since relatively little has been written about the development and characteristics of rural hospital consortia, an essay such as this inevitably raises issues that deserve closer scrutiny by policymakers and health service researchers. For example, do consortium structures evolve in a predictable way with age? What are the benefits and costs of more formal, versus less formal, organizational structures? Why are consortia more prominent in some states than in others? Where multiple consortia exist, is there competition among them? If so, what form does that competition take? What factors determine the kinds of activities consortia undertake? How committed are individual hospitals to specific activities within consortia? We will be able to address many of these questions through a follow-up consortium survey, as well as a survey (already completed) of administrators whose hospitals participate in consortia. These surveys also were funded by The Robert Wood Johnson Foundation as part of the HBRHC program.

Our analysis of interview responses from consortia participating in the HBRHC program suggests that environmental forces, such as growing competition from urban providers and regulatory constraints, may have created a climate supportive of consortium development. However, it is not clear at this time if a hostile environment is a necessary precondition to consortium formation, nor is it clear that consortia in hostile environments function more effectively than those in more benign environments. In our future work, we will attempt to track significant environmental changes at the HBRHC sites and assess their importance for the long-term viability of consortia. Additionally, a quantitative analysis of consortium impacts will introduce independent variables that are meant to capture environmental variation across consortia and hospitals and measure the impact of consortium participation on rural hospitals’ financial performance.

**Role of third parties.** Our interview data strongly suggest that the involvement of a third party facilitates rural hospital consortium implementation, particularly in the initial, developmental stages. It is not clear, however, whether such involvement is a necessary condition for consortium formation. It may be simply an artifact of the HBRHC program, in which a third party’s participation may have been required to assist with the writing of a proposal to The Robert Wood Johnson Foundation. Alternatively, particularly when the third party is an urban hospital, it could signify that at least some important benefits of rural hospital consortia accrue to nonrural providers or other parties. This issue will be addressed in subsequent interviews with consortium administrators and
in a follow-up survey of consortia nationwide. The issue is potentially important for policy purposes, since it bears on the sorts of external assistance that rural hospitals may require if consortia are to be encouraged through public policy and on the relative degree to which the benefits of consortia remain in rural areas.

The consortium survey and interview responses taken together raise the interesting issue of whether rural hospital consortia have a natural “life cycle” and, if this is the case, if policy intervention at some points in that life cycle could be more effective than at others. The analysis of consortium operations over the course of the HBRHC program should provide some evidence on this issue, since the HBRHC consortia entered the program with great variation in their experience and sophistication with respect to group activities.

Emergence of leaders. Finally, our interview data suggest that the strongest, often the largest, rural hospital in a consortium typically emerged as its leader. While this was sometimes viewed with suspicion by other consortium participants, it was also acknowledged as necessary in most cases. The weaker hospitals in the group simply did not have the requisite resources or stature to push forward the development of the consortium. This raises important questions concerning the composition of consortia and their objectives. Is a consortium more accurately portrayed as a collection of small, struggling rural hospitals, or as a strong lead hospital encouraging and facilitating the participation of other, weaker hospitals? If the latter is the more accurate portrayal, then the distribution of the benefits of consortium activities deserves close scrutiny. It may be that rural hospital consortia benefit rural hospitals that need the least help, while providing little assistance for struggling facilities. Alternatively, a “win/win” outcome is certainly possible, with stronger facilities benefiting but weaker consortium participants gaining as well from consortium participation.

Role of grantmakers. As we noted at the beginning of this article, the growth of rural hospital consortia has been stimulated in part by the grant programs of private foundations and the federal government. These programs were based on the hypothesis that collective actions could help rural hospitals address common problems. While participation in consortia is now common for rural hospitals, relatively little is known about the benefits of that participation, either from the perspective of the individual rural hospital or from the perspective of the overall delivery of health services in rural areas. To build on past private foundation and government efforts, support will be needed to evaluate the effectiveness of various consortium organizational structures and programs. The findings of these studies will need to be disseminated to
assist consortia in their decision making. The HHS Office of Rural Health Policy provides a potential public-sector focal point for this dissemination effort. Foundation support also could play a valuable role in funding hands-on, technical assistance related to consortium formation and the implementation of specific activities.

Work on this article was supported by Grant no. 11949 from The Robert Wood Johnson Foundation.

NOTES

6. Senate Staff Report to the Special Committee on Aging.
7. Ibid.
9. Senate Staff Report to the Special Committee on Aging.