

What Should be Done About Rural Health Care?

by John C. Goodman

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Last year, Republicans in Congress cut Medicaid outlays and refused to extend Obamacare's enhanced subsidies. Yet less federal spending on health care threatened to affect a key Republican constituency: rural voters. To avoid hostile retaliation for their actions, Republicans included [\\$50 billion for rural health care](#) in their "[big, beautiful bill](#)," to be spent in various ways.

The bad news. Even before last year's legislative actions, rural areas in the U.S. were losing [doctors](#), [hospitals](#) and even [pharmacies](#). That trend is likely to continue, and neither party has a realistic plan to deal with it.

According to a [report from the Commonwealth Fund](#), 43 million Americans now live in rural communities facing a shortage of primary care providers. Even before funding was slashed, nearly half of rural hospitals were operating in the red, and [almost 100 have closed or been unable to provide inpatient services in the past decade](#). Nearly half of U.S. counties contain at least one "[pharmacy desert](#)" -- places where people must drive more than 10 miles to fill prescriptions because no pharmacies exist nearby.

Some good news. On the other hand,

- [More than 96% of Americans](#) live within 90 minutes of a full-service hospital. That is the time span within which a procedure

can be used to open a blocked coronary artery during a heart attack – avoiding death and disability. By contrast, only 71% of Canadians live within that window.

- [Specialists at the Mayo Clinic](#) are treating thousands of stroke victims in rural settings every year across several states via telemedicine – usually within minutes of their arriving at the ER.
- Drones can deliver blood, vaccines, and emergency medicines to rural hospitals. This includes clot-busting drugs (for strokes), antivenom (for snake bites), and antibiotics (for trauma). In fact, drones are already doing this on a regular basis in [many African countries](#).
- Nurses practicing at the top of their training, foreign trained medical doctors, and U.S. medical students without a residency can provide many of the services that are not being provided by conventional medical doctors.
- [Different payment methods](#) (such as a monthly fee for all primary care) are replacing fee-for-service medicine with 10,000 different billing codes that impose huge administrative costs on small medical practices.

Even so, there is more bad news. In order to take full advantage of telemedicine, drones, alternative medical personnel and different payment systems, we need changes in dozens of state and federal laws.

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Telemedicine. In general, a doctor in one state can't care for patients in another state unless that doctor is licensed in both states. For Mayo Clinic doctors to treat stroke victims in all 50 states, that means the doctors need to be licensed to practice in all 50 states.

During Covid, most states suspended their restrictions on telehealth across state lines. However, most of these restrictions have since been reimposed. Where you find exceptions, there are usually many legal hurdles that are costly and burdensome to surmount.

In an ideal world, doctors licensed to practice in any one state would be free to practice in any other state via telehealth. Also, we should move to a new way of paying for such care.

Under the current system, what doctors get paid depends on a multitude of billing codes and the insurance status of the patient – Medicare, Medicaid or private insurance. Yet what matters most in treating stroke victims – speed, quality and availability – are not part of any billing code.

The case for free market competition and free market pricing is stronger in telehealth than in any other aspect of medicine. We should let institutions like Mayo compete for the business of local communities just like firms compete in other markets.

Further, achieving the ideal shouldn't be that difficult. The last time I looked, Congress has the power to regulate interstate commerce.

Use of drones. Drone technology could also be a life-saver for patients in rural communities. You would think that in a large rural state like Texas, drone delivery of drugs, blood and medical supplies would be commonplace. In fact, hospitals in [Dallas](#) and [Houston](#) have experimented with drone deliveries to homes – but only in these two, large cities.

To have a drone delivery system for rural Texas, medical centers must confront a host of federal

aviation regulations. Plus, Texas has its own state regulations and cities can pile on local regulations as well.

When it comes to making use of drones, Texas (along with other U.S. states) is living in the technological Dark Ages – especially in comparison to the robust programs underway in such countries as Rwanda, Ghana, Nigeria and Kenya.

Liberating potential providers. This is another pathway we should follow. Right now, [only 27 states](#) allow nurse-practitioners to practice to the full extent of their training. Texas is one of 11 states that do not allow nurses to do much of anything without a doctor's supervision.

If doctors want to live in big cities, Texas nurses who want to practice at the top of their training also have to locate in big cities so they can be "supervised." The cost of such supervision can be doctor payments that total as much as [\\$50,000 a year](#). Right now, these nurses are an [untapped potential resource for rural health care](#).

Advanced practice registered nurses lower the cost of care. A [2013 study](#) estimated there would be nearly \$2 billion in savings if all states allowed nurses practitioners to practice independently.

Nurse practitioners also increase the quality of care. An [essay in The Hill](#) noted that

A [2023 study](#) finds that rather than increasing malpractice claims, relaxing practice restrictions on advanced practice registered nurses results in a 21 percent to 24 percent reduction in physician malpractice rates, with no increase in advanced practice registered nurse malpractice claims.

Other sources of medical personal include [foreign-trained doctors](#) and medical school graduates who do not obtain a residency ([about 7% of the total](#)). These professionals could provide [on-site primary care](#), which is the kind of care most appropriate in rural areas.



Direct primary care. As noted, rural areas could benefit from or need different payment systems. What used to be called “concierge care” for the wealthy now goes by the term “direct primary care” (DPC) when it is made affordable for most families. [Atlas MD in Wichita](#), for example, charges \$50 a month for a mother and \$10 for a child in return for all primary care along with the doctor’s phone number. This type of 24/7 care avoids the administrative cost of thousands of billing codes and allows doctors to practice medicine the way they were taught in medical school.

An important feature of the big, beautiful bill now allows Health Savings Accounts (HSAs) to be used to pay the monthly fee of DPC doctors. Employers can make deposits to those accounts and employees can contract with a DPC doctor of their choice.

We also need to allow HSAs and access to direct primary care for enrollees in Medicare and Medicaid. This would allow rural patients to have options for primary care both on site and via telehealth.

Hospital deregulation. We need to deregulate the hospital sector. For example, “certificate of need” laws make it difficult or impossible to open new health care facilities. Every presidential administration since [Ronald Reagan’s](#) has called on states to repeal certificate of need laws.

Nonetheless, the essay in [The Hill](#) noted that:

More than 30 states continue to enforce those laws, which, for example, [prevent ambulance providers from reaching rural Arizona](#); led to the death of a newborn [by keeping one Virginia hospital from opening a neonatal intensive care unit](#); and contribute to the national [crisis in](#)

[hospital boarding](#), whereby patients are stuck in ER beds for weeks or months because there are no beds available in existing substance-use treatment or psychiatric facilities.

Deregulating health insurance. Among regulatory barriers that negatively impact access to rural health care are the [network adequacy rules](#) for Medicare Advantage (MA) plans. In general, MA plans are required to have a minimum number of doctors and hospitals in their networks. These requirements are hard to meet in rural areas, however, where there are few doctors and maybe no hospitals.

The Centers for Medicare and Medicaid Services (CMS) holds rural areas to a lower standard and even allows telehealth to count in determining adequacy. Even so, KFF (Kaiser) estimates that [39% of US counties](#) have only 1 or 2 MA insurers. (By contrast, in large urban areas, there may be as many as 40 plan options.)

More could be done. And making it easier for MA plans to meet rural health care needs helps the entire market.

One [recent study](#) finds that an increase in county MA penetration is associated with an increase in hospital financial stability and a reduction in risk of hospital closure. In fact, the study found that every percentage point increase in MA penetration was associated with a 4% reduction in risk of hospital closure.

Note that liberalizing scope of practice laws and deregulating the hospital and insurance sectors do not cost money. These measures save money. That would allow the \$50 billion for rural health care to have an even larger impact.



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