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Health Care's Role in the Rural Illinois Economy

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Introduction

A basic question in rural economic development in the United States today is "What is the role of health care in community development efforts?" As the largest industry in the United States and one projected to grow even larger during the coming decades, every rural community must assess its ability to benefit from these healthcare changes. In almost every rural community, health care will play a role in economic development. In some places, it may be the dominant employer and source of economic growth. In other places, this industry will be a small part of the local economic picture. Regardless, communities should actively plan and assess the role of health care in their economy.

The Role of Health Care in the National and Rural Economy

The economic importance of the healthcare sector nationally can be demonstrated by examining the percent of total employment and gross national product (GNP) associated with healthcare activities. Recent national data show that healthcare expenditures represent about 15 percent of the GNP (U.S. Bureau of Economic Analysis 2004). Healthcare employment makes up 9.4 percent of U.S. employment. The magnitude of healthcare expenditures and the percent of the GNP devoted to health care continues to increase.

During the past two decades, healthcare services have become a critical engine of growth in rural America. In 1980, healthcare industry earnings represented 5.7 percent of all industry earnings. By the late 1990s, the healthcare share of industry earnings had risen to 12.5 percent in rural America. These statistics indicate that for many rural communities, the healthcare sector is often the second largest industry category, trailing only local government employment (Doeksen 2000; Scorsone 2001). Furthermore, medical transfer payments, such as Medicare and Medicaid, now represent more than 9 percent of rural residents' personal income.[1] By contrast, in 1980, these payments represented only 2.9 percent of personal income.

Why is the healthcare sector growing so quickly in urban and rural America? The healthcare industry is in part responding to the growing levels of retirement and medical transfer payments from Social Security and Medicare. According to the current literature, rural hospitals derive approximately 50 to 80 percent of their total funding from public sources—mainly from Medicare and Medicaid (Doeksen 2000). The patient mix is approximately 60 to 80 percent Medicare or Medicaid recipients for most rural hospitals.

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[1] The federal government's economic data system counts Medicare and Medicaid payments to healthcare providers as income to the residents who are beneficiaries of the services. These payments in essence act as income to these individuals.

The situation in rural Illinois mirrors the national experience. In 1990, the share of personal income derived from healthcare services was 4.0 percent, and this share had grown to nearly 5.0 percent during the decade. In several counties, this share is much higher and shows the strong presence of health care in the local economy (U.S. Bureau of Economic Analysis 2004). In rural Illinois, the Cape Girardeau-Jackson, Carbondale, Effingham, Mount Vernon, Charleston-Mattoon, and Quincy micropolitan areas are all examples of rural communities with a significant healthcare presence in the local economy. These areas typically have healthcare sectors which represent more than twice the national average of health care's share in local economies around the country.

Several factors are behind the growth and importance of health care in these communities. In almost every case, the communities have a large hospital or hospitals that anchor the local healthcare system. Some communities are home to university-based healthcare services. Micropolitan communities—rural areas with larger urbanized settlements—seem the most likely to have significant healthcare systems; however, this general rule is not true in all cases, and micropolitan areas in northern Illinois show a much smaller degree of health care in local economies. This does not mean that the need in northern communities is automatically eliminated, but the potential opportunities in these regions may be limited (U.S. Bureau of Economic Analysis 2004).

A Framework for Understanding the Role of Health Care in Rural Economic Development

Financial Linkages. The local healthcare system plays a major role in rural economic development within a community predicated on linkages between health care and the rest of the local economy. These linkages can be both financial and nonfinancial. Financial linkages are based on monetary flows between the healthcare sector and other industries and consumers. In particular, the healthcare sector purchases goods and services, including equipment and supplies. To the extent that these supplies are purchased from local businesses, they spur economic development by creating jobs and new income sources. Further, healthcare employees spend their income on homes, cars, food, and other items. Again, to the extent that these are local purchases, they will cause subsequent job and output growth in local businesses.

To illustrate these financial linkages, an employment multiplier is often applied. The employment multiplier describes the spillover relationship between the healthcare sector and other local industries. Based on research over the past two decades, the typical rural employment multiplier ranges from 1.2 to 1.8 (Doeksen, Johnson, and Willoughby 1996), which means that for every job in the local healthcare system, another 0.2 to 0.8 jobs are created in other local industries. This connection is due to the expenditures of the healthcare sector and healthcare sector employees reverberating throughout the local economy. Their expenditures also create jobs in other local industries and companies.

Resulting healthcare expenditures are due to the intake of revenues. The loss of revenues due to patient migration to urban centers is a significant problem for many rural healthcare providers. This trend is known as outshopping when patients bypass a local healthcare provider to receive care in another community. Outshopping reduces the size of the multiplier and the economic impact of health care on the local economy. Outshoppers bypass local healthcare facilities, such as the hospital, clinic, pharmacy, or any other healthcare provider, and obtain healthcare services outside their counties.

Nonfinancial Linkages. Besides financial linkages, the healthcare industry may influence local businesses and residents in other ways. These influences are especially important in two ways. First, health care may be a key asset in attracting other companies to the region. Evidence suggests that firms seek communities with many attributes, including a strong healthcare system (Doeksen 2000). A strong healthcare system can ensure access to care for employee recruitment and retention and potentially reduce costs for employers. Second, health care may be part of a quality of life strategy to ensure attraction and retention of population. A community attempting a retiree-based rural development strategy must consider the quality and quantity of the local healthcare infrastructure. Retirees often cite the importance of health care in choosing a location for a first or second home (Doeksen 1996). Finally, a comprehensive local healthcare system can potentially lead to improvements in worker productivity and reduced absenteeism through preventative care programs.

Health Services and the Rural Illinois Economy

The economy of rural Illinois has changed dramatically during the past few decades, and health care has played a major role in shaping that transformation. Since the 1960s, the rural Illinois' economy has moved from one based on agriculture and natural resources to one based on manufacturing and services. While agriculture still controls the rural landscape in terms of dollar flows and employment, non-agricultural industries are now dominant in rural economies.

Healthcare services, in gross terms, have nearly doubled their share of personal income in rural Illinois. In 1969, healthcare services represented 4 percent of the rural Illinois economy, while by 2000, it was nearly 8 percent (U.S. Bureau of Economic Analysis 2004). These changes translated into a growth rate of more than 800 percent over the last thirty years. Compared to those changes, manufacturing, construction, retail trade, and finance all grew in the 300 to 400 percent range during the same time period. These trends make health care one of the fastest growing industries in rural Illinois.

The growth of health care in the economy was, in most cases, not a planned event, but the result of secular trends at the state and national level. Very few communities actively recruit for, or place a focus on, the healthcare sector in their economic development strategies. The conventional wisdom is that health care is a tertiary industry that simply grows or declines in the face of other industries (Doeksen 2000). For example, if manufacturing, agriculture, mining, or other basic industries grow, the healthcare sector will also grow due to increased demand from these industries' employees and families.

In many cases, however, the conventional wisdom has been upset because of demographic and business changes in healthcare services. Today, it is more likely that health care is a driving force in the local economy. The healthcare industry has replaced manufacturing or agriculture as the dominant industry in many locations. Further, healthcare service employment and income growth is not driven by other industries; rather, it is primarily generated by demographic changes. **Table 1** shows the share of healthcare services in county economies across Illinois.

The information in Table 1 provides one perspective on analyzing the economic importance and potential economic development for a county healthcare system. In some counties, a high percentage share of health care in local personal income is due to high average wages; in other

Table 1. Rural Illinois County Healthcare Services by Percentage of Total Income, Employment, and Average Salary

County	*Share of Income*	*Share of Employment*	*Average Wage*
Adams	8.84	15.96	29.18
Alexander	7.61	19.68	21.53
Bond	2.89	13.50	24.90
Brown	2.28	8.92	18.27
Bureau	4.51	17.53	25.10
Calhoun	1.89	14.08	10.01
Carroll	1.59	12.09	12.51
Cass	3.26	9.88	15.54
Christian	4.59	16.24	20.72
Clark	2.11	7.78	18.48
Clay	1.62	11.96	19.61
Clinton	2.81	19.62	19.36
Coles	9.07	14.63	30.53
Crawford	2.09	9.64	19.81
Cumberland	1.58	24.83	15.84
De Witt	1.15	14.74	26.94
Douglas	1.90	4.76	17.90
Edgar	3.89	14.66	17.90
Edwards	1.25	3.49	20.06
Effingham	8.55	14.99	27.74
Fayette	3.79	15.59	21.09
Franklin	2.94	16.36	17.47
Fulton	4.89	25.26	22.23
Gallatin	N/A	N/A	N/A
Greene	2.21	16.57	15.18
Hamilton	1.36	36.38	16.99
Hancock	2.78	11.24	19.59
Hardin	4.45	46.18	15.60
Henderson	1.47	18.98	18.54
Iroquois	5.33	23.30	20.95
Jackson	4.39	20.33	26.01
Jasper	9.85	4.68	20.12
Jefferson	0.86	19.43	26.45
Jersey	8.83	18.78	20.54
Jo Daviess	2.48	7.19	20.26
Johnson	1.43	10.88	19.51
Kankakee	5.34	15.78	31.87
Knox	0.76	23.10	24.24
La Salle	7.47	13.25	24.37
Lawrence	3.19	25.30	15.70
Lee	3.61	17.52	29.45
Livingston	6.07	12.92	25.13
Logan	3.77	14.90	20.95
Macoupin	7.20	14.93	17.68
Madison	2.58	15.05	26.90
Marion	5.11	18.83	23.04
Mason	1.40	15.09	20.49
Massac	3.13	14.36	18.58
McDonough	2.98	13.39	29.56
Monroe	1.44	10.81	19.46
Montgomery	5.55	16.69	22.65
Morgan	5.74	17.59	22.23
Moultrie	3.59	22.14	17.07
Ogle	2.32	7.38	22.35
Perry	2.82	14.70	20.89
Pike	3.58	20.94	20.10
Pope	N/A	39.02	16.64
Pulaski	N/A	26.54	14.93

Table 1 con't

County	*Share of Income*	*Share of Employment*	*Average Wage*
Putnam	0.71	1.22	12.47
Randolph	3.44	21.64	25.71
Richland	7.31	15.73	25.67
Saline	7.31	28.59	17.20
Schuyler	1.46	22.52	20.70
Scott	0.75	1.60	34.55
Shelby	2.54	15.64	21.11
St. Clair	6.18	16.81	30.26
Stephenson	5.91	14.16	26.53
Union	3.97	43.70	22.60
Wabash	1.89	22.53	13.40
Warren	3.57	15.42	16.12
Washington	1.81	12.02	18.73
Wayne	2.98	16.75	18.56
White	2.72	20.73	17.49
Whiteside	3.29	16.45	24.48
Williamson	4.93	19.54	26.90
Average	3.74	17.00	21.21

N/A: Not Available

Source: U.S. Bureau of Economic Analysis 2004.

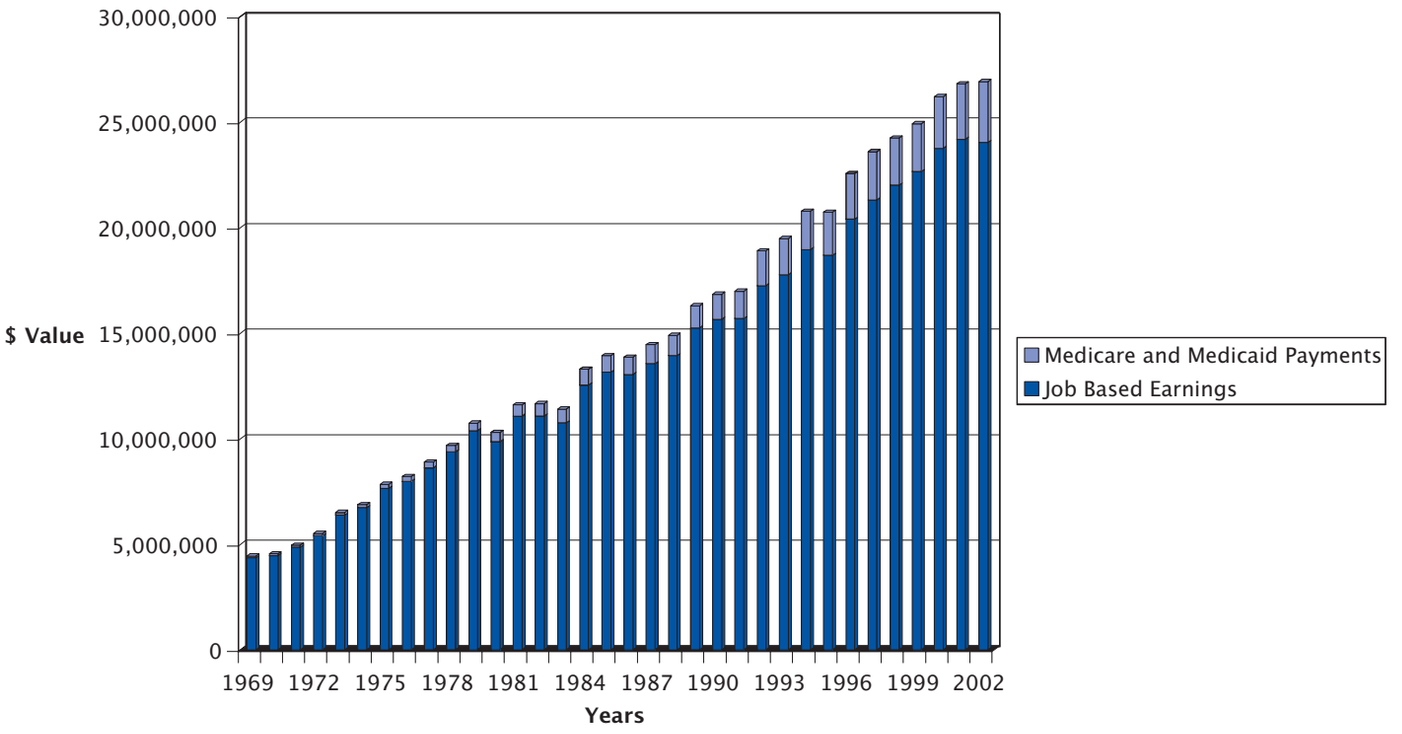
cases, it is due to a large proportion of local jobs in health care. For example, Coles County has one of the highest percentages of healthcare earnings as a share of county personal income. It does not have an above average share of healthcare jobs compared with other private sector jobs, but average wages are high relative to the state average. This may reflect the type of occupations that exist in the county. Despite the limitations, this information can help assess the potential impact of healthcare expansion on the local employment market as well as the quality of jobs created through average wage levels.

Personal income is one of the broadest available measures of well-being at the local or regional level. Since 1969 (the first year regional economic data is available), nonjob earnings such as dividends; interest payments; property rental agreements; and government transfer payments such as Medicare, Medicaid, and Social Security have grown much faster than job earnings. In 1969, nonjob earnings were only 25 percent of the total personal income. Today, these same income flows represent 40 percent of personal income in rural Illinois.

Medical transfer payments, mainly Medicare and Medicaid, are important drivers of the rural Illinois economy. In 1969, these transfer-based income flows represented a mere $88 million in rural Illinois. In 2002, these transfer-based income flows are now $2.8 billion. In 1969, the medical transfer payment program represented only 1.5 percent of the rural Illinois economy, while by 2002, it represented 7.5 percent. This enormous increase came at the expense of job earnings whose share of personal income dropped. Chart 1 depicts these changes, showing medical transfer payments as compared to county gross job earnings.

Because Medicare, Medicaid, and other medical transfer payments must be spent on medical or healthcare services, we can directly attribute their economic impact to healthcare industries; however, the extent of the leakage from the rural economy is less easily tracked. While Medicare and Medicaid "income" is traced to the county of residence of the beneficiary, the expenditure of these funds may or may not occur in rural Illinois. If these income sources leave the rural area, they represent lost opportunities for rural job creation and income growth.

Chart 1. Medicare/Medicaid Payments as a Share of Rural Illinois Personal Income



Source: U.S. Bureau of Economic Analysis 2004.

Outshopping for Health Care

It is critical to assess the degree and importance of rural outshopping to rural Illinois. This outshopping represents expenditure leakages from rural to urban centers. The current literature shows that consumers (patients) bypass their local healthcare centers or hospitals about one quarter to one third of the time (Scorsone, Adams, Burke, and Doeksen 2004). In other words, approximately 25 to 30 percent of the rural population travels outside their local areas to obtain those services. It appears that a majority of outshoppers do travel to urban areas when they seek healthcare services. Inshoppers (consumers who seek local healthcare services) may place a higher value on personal time and perceive the local hospital as more convenient. In general, the literature indicates that inshoppers believe that the local quality of care is greater or equal to those services obtained from urban healthcare facilities (Buczko 1994).

The data for rural Illinois show a situation similar to the experiences documented in other studies (Buczko 1994, 1997). **Table 2** describes the proportion of individuals who left their home county to receive in-patient medical care in another county. While the data does not document the exact extent of rural to urban patient flows, it does show that rural residents leave their home county more often than urban residents. These leakages reduce revenue for local healthcare systems in cases in which an identical healthcare service is available locally.

Table 2. Urban and Rural Illinois Resident Outshopping Percentages, 2001

Urban residents	Stayed in county	80.9%
	Left county	19.1%
Rural residents	Stayed in county	65.8%
	Left County	34.2%

Source: Illinois Cost Containment Council Data compiled by the Illinois Institute for Rural Affairs, 2001.

Age, gender, scope of services, income level, and insurance seem to have the greatest impact on consumer decision-making with regards to healthcare services (Taylor 1997; Taylor and Capella 1996). For example, younger adults seem to have a greater propensity to seek healthcare services from urban hospitals. Younger adults seem to prefer the quality of health care obtained from urban hospitals over services

available from their rural counterparts. Higher income consumers, who are more likely to be insured, seem to follow the same decisionmaking trends as younger adults.

To the contrary, older adults (especially retired and Medicare patients) and uninsured individuals are more willing to purchase services from local healthcare centers and hospitals. It is still unclear whether Medicare and low-income patients who utilize local services do so because of transportation factors or simply the willingness of local professionals to provide charity care. The current literature shows that when Medicare (elderly) patients bypass the local hospital, it is because those needed services are not available within the community. When elderly adults outshop for healthcare services, a large percentage of them travel to larger rural regional medical centers. An important but disturbing trend is that the elderly and uninsured do not seek local physician care. This may be due, at least in part, to the fact that local physicians limit the number of Medicare and Medicaid patients, and this influences where patients seek healthcare services (Buczko, 1994, 1997).

In general, the literature suggests that women are more willing to use local healthcare services than men (Taylor 1997); even so, young adult women in rural areas seem to bypass local medical centers or hospitals due to lack of specialty services such as obstetrics, gynecology, and specialty pediatrics (Rieber, Benzie, and McMahon 1996). As with other consumer groups who outshop (especially Medicare patients), the choice to bypass may be a function of available services rather than an intentional decision not to utilize local services. Specialty services such as obstetrics, gynecology, and pediatrics may be beyond the scope of the available services provided by the local hospital or clinic. Thus, it may not be financially feasible for a local hospital or medical center to provide specialty services such as obstetrics or high-level surgical procedures to local residents.

The outshopping information and research provided here could be used by local decisionmakers to analyze potential expansions in local healthcare services. These services could be targeted to reduce the potential outflow of patients and associated revenues. In some cases, it may be impossible for a community to provide a specific service; however, local healthcare providers may be able to partner or network with larger regional healthcare systems to ensure a continuity of care and at least a small reduction in revenue outflows.

Moving Forward: Health Care's Future Role in the Economy

Although health care may play an important role in a local economy today, the question remains which services will be available in the future. In other words, how can community leaders and economic development officials work with the healthcare industry to ensure the continued growth and prosperity of the healthcare sector. This section discusses the potential strategies a community can use in appropriately enhancing the role of health care in economic development.

Policymakers and concerned residents should consider several key policies when assessing the future role of health care in the local economy:

- Projected changes in local and regional healthcare demand
- Diversification of the local economy
- Potential for a local healthcare cluster
- Healthcare capital access
- Workforce development

Each policy issue will be discussed in detail.

Demand for Health Services. Any attempt to stimulate health care via an economic development strategy must consider the demand for the underlying services. Without potential or actual demand for a specific healthcare service in a local area or region, a sustainable financial basis for the proposed facility is unlikely. Communities or agencies are strongly encouraged to assess the demand and feasibility of any undertaking.

Concurrently, the demand for healthcare services is dynamic and changes over time. Therefore, proposed facilities or services may be able to take advantage of demographic or business changes in a community. For example, a major influx of retirees or immigrants may signify a changing demand for healthcare services. New procedures or practices in medicine may stimulate a demand among the current local population. Factors such as these should be considered when assessing the financial sustainability of a healthcare service or facility.

For example, in rural western Kentucky, one community has recently constructed an industrial park with several large potential manufacturing clients. This industrial expansion has opened the possibility of a wellness center and primary care clinic managed by the local community hospital in the industrial park. This facility can provide a basic level of preventative and acute care to workers in

that area. A feasibility analysis was undertaken to help the hospital determine the optimal level of services and the potential demand that would eventually be created by the industrial park.

Health Care and the Diversified Economy. Another factor to consider is whether a community is too dependent on the local healthcare system, keeping in mind that a community should avoid being too dependent on a single major employer. Many changes in the healthcare system are based on state or national policies and are beyond local control. If a local economy is dominated by one or more healthcare employers, it may be time to pursue other economic development strategies. At the same time, if health care is a small portion of the local economy, it may be to a community's advantage to invest in developing healthcare services. Illinois policymakers can consult Table 1 to estimate their dependence on health care. Other potential sources of information include the U.S. Bureau of Economic Analysis (**www.bea.gov**) and the U.S. Census Bureau (**www.census.gov**).

Rural Health Care Clusters. A counterargument to diversification is that some communities can become hubs or clusters of the healthcare sector. A cluster is defined by Michael Porter (1998) as "geographic concentrations of interconnected companies and institutions in a particular field" (p. 78). Many definitions of clusters have been provided. Usually, a cluster refers to an industry with strong supplier or workforce linkages in a geographic region. These linkages are a major factor behind the growth and prosperity of the industry in that region. Companies and organizations that are part of a regional cluster will be more productive and able to pay higher wages to employees. Again, quoting Porter (2000), "the presence of [a] well developed cluster provides powerful benefits to productivity and the capacity to innovate that are hard to match by firms elsewhere" (p. 16). Through these mechanisms, a cluster generates greater economic growth in the region.

The downside of a cluster is that it requires a heavy dependence by a region on one or more highly linked industries. A problem in one industry can have major consequences for firms and organizations throughout the region. This can ultimately lead to lower economic growth and higher unemployment in the region.

A high proportion of a local economy dedicated to healthcare services is a potential, although not definitive, sign of a healthcare cluster. A true cluster would be signified by direct and indirect linkages between healthcare providers and between healthcare providers and other local industries. Large institutions, such as a hospital or nursing home, are often a centerpiece of a cluster. In the case of health care, workforce linkages are likely to be evident as employers have a large pool of applicants to draw from due to the concentration of providers in the area. For example, with two or three hospitals in a region, skilled professionals, such as radiologists, may be drawn to the area, creating a larger base of potential employees for local hospitals. This pool of employees may also show others that job opportunities exist in those fields locally.

Rural Illinois has several counties and micropolitan areas where health care is a significant industry. As noted earlier, Coles County, Illinois, is one example. Fifteen percent of the private sector labor force is employed in health care, and nearly 10 percent of personal income is derived from healthcare services. Based on these statistics, a potential healthcare cluster may exist in this community. According to research from the University of Illinois, Coles County has a much higher proportion of physicians per capita (1.55 MDs per 1,000 persons) than the national average (1.17 MDs per 1,000 persons) or even the Illinois average (1.01 MDs per 1,000 persons) (McNamara, Hancock, and Quick 2002). Coles County also has a significantly higher level of Medicare reimbursements ($19.4 million in 1991) than the average rural county in the U.S. ($10.4 million in 1991). All of these statistics point to a community influenced by the healthcare sector at a much higher rate than the rest of the nation.

Based on U.S. Census Bureau (2001) data, Coles County is home to more than 120 healthcare establishments. These include physicians' offices, dentist offices, outpatient centers, home healthcare services, and two community hospitals. There is evidence that a community hospital typically has a large impact, directly or indirectly, on other local healthcare providers (Doeksen 2000). In Coles County, the employment multiplier is estimated to range between 1.16 and 1.74, depending on the specific healthcare establishment. For example, Coles County physicians' offices create an additional .74 jobs for every job created directly by these offices. These economic multipliers do not account for the dependence of physicians on access to local hospitals or clinics. Finally, several nursing homes and residential mental health facilities are located in the community. It can be argued, therefore, that in communities where the healthcare industry makes up a significant proportion of the local economy and where these other linkages are present, a type of cluster may exist.

Clusters are often supported by government or university-based programs. In Coles County, Eastern Illinois University (EIU) plays an implicit role in sustaining this type of rural healthcare cluster. In particular, EIU supports the training of new employees for local healthcare providers.

It offers several medical profession training programs in cooperation with other colleges and universities (**www.eiu.edu/~premed/**). This type of training and educational program can strengthen the pool of employees for local employers and drive down employment search and training costs.

The combination of a significant concentration of healthcare establishments and employees and supportive local institutions makes Coles County, Illinois, an example of a potential rural healthcare cluster. For the potential to be fully realized, the community must come together and form an explicit alliance or collaborative partnership that recognizes the potential cluster and builds more supportive institutions. In many cases, these rural healthcare clusters emerge not from any grand design, but, rather, from the logic of the market which dictates that healthcare providers prefer to cluster near hospitals.

The question then is, "Should a community pursue a deliberate economic development strategy to strengthen or retain such a cluster over time once it is identified?" The answer to this question depends on whether the community feels it has a competitive advantage compared with neighboring communities. In particular, the cluster must be able to sustain an increasing demand for services based on demographic changes or the specific competitive advantage of healthcare service offerings compared to neighboring communities. Very few examples in rural America of explicit healthcare clusters exist.

Several other factors may influence the selection of a healthcare-based cluster strategy. One factor that must be addressed is assessing the potential market area for local healthcare providers. The possibility may exist to expand market areas and offer competitive services compared to other regional healthcare providers. Also, the presence of many establishments may be used as a recruiting tool for healthcare service institutions and healthcare employees. Finally, a community must assess the benefits of clustering against the costs. In Coles County, significantly higher average wages, as compared to the state average, may be a sign of significant opportunities despite the fact that costs may be higher for local healthcare providers.

Capital Access. Many small, rural hospitals need facility upgrades, maintenance, and construction to stay competitive. In the face of limited physical capital facilities, many consumers place considerable weight on capital access as a major component in modernization efforts. In most cases, a low-cost capital program would provide access to low-interest loans that can be used to upgrade and repair facilities. Capital access is part of a strategy to retain current customers and future residents in order to reduce the level of outshopping from a rural community. One example of this type of program is the Southern Rural Access Program (SRAP) (2002). A component of this fund is a revolving loan program that allows local physicians, hospitals, or other healthcare providers to borrow money at low-interest rates for capital improvement projects. These loan funds were established in Arkansas, Mississippi, Louisiana, South Carolina, and West Virginia. The experience with these funds is that there is a need for capital access for small and moderate-sized projects; however, extensive marketing and staff support is required to successfully operate the funds (Stewart, Beachler, and Slayton 2003). This type of revolving loan fund is similar to traditional loan funds used for small business development in many rural communities.

Workforce Development. Workforce development strategies can also be effective as tools to connect health care and economic development. Workforce development is a critical tool to improve the productivity of existing workers and to attract new workers into the community. Labor productivity is important to the overall sustainability of healthcare providers and to the industry's contribution to local economies. Programs include residencies, internships, and career fairs in local schools. A high-quality workforce is necessary to improve the labor productivity of healthcare providers. Hospitals, local community foundations, chambers of commerce, and other organizations may be willing to sponsor scholarships or other financial incentive packages to train youth in health professions and to ensure a steady workforce in the region.

Western Michigan University (Kalamazoo) (Fuller 2001) is an example of a rural workforce development program. The Rural Health Education Program is designed to provide a rural context for health profession training at the university. Several approaches are used in this program. Students are immersed in interdisciplinary training in the classroom and in clinical experience. They are exposed to the challenges and rewards of working in a rural environment. They are also expected to participate in a summer internship program with the Institute of Migrant Farm Worker Health in southwest Michigan. All of these programs build a workforce that is well-prepared to work in a rural health setting and that has undertaken activities and networking with local rural healthcare providers who will serve as future employers.

A "Rural Health Leaders Pipeline" was developed in rural Alabama (Rackley et al. 2003). This program targets high school juniors and seniors to increase their interest and desire to pursue a healthcare profession. Students shadowed healthcare professionals and introduced medical concepts into high school curriculum. To date, the program

has experienced success in recruiting minority students into healthcare professions; however, it is an expensive program that requires a long-term commitment.

In Illinois, workforce strategies are collaboratively being addressed through several programs. The Rural Medical Education Program (RMED) trains medical students in rural medicine, giving individuals the necessary skills to practice in rural areas. Through the Illinois Department of Public Health–Center for Rural Health, there are scholarships available for physicians returning to a rural area. The Illinois Area Health Education Centers (AHEC) Program offers a rural interdisciplinary fellowship program to provide training for rural practitioners on collaborative projects and to foster an environment for future preceptor sites for rural health professionals. The program's slogan is "Growing Our Own . . . ." The program encourages collaboration among local providers to tackle health-related issues and learn from each other's expertise. Through the Illinois Rural Health Association, the Illinois AHEC Program, the RMED Program, the Illinois Institute for Rural Affairs, and others come together to offer high school students the opportunity to learn about health professions at a Health Careers Camp. Students are exposed to various health professionals practicing in a rural setting. These are just some of the ways Illinois organizations and agencies are coming together to address the workforce shortages in rural areas.

Conclusion

Based on earlier discussions, each community must assess the appropriate role of health care in its own situation. In some cases, healthcare expansion is financially feasible and will lead to improvements in the local economy. For other communities, however, health care may play a restrictive role in growing or stabilizing the local economy. The information in Table 1 will assist decisionmakers in assessing the current state of health care in the local economy.

Understanding the healthcare issues and important role of these key policy issues is helpful as communities begin to assess and plan for the role of health care in the local economy. Rural communities have valuable resources for assessment and planning efforts. IIRA's Health Resources and Rural Economic Technical Assistance Center works with rural communities throughout the state to provide health and economic data. Through a network of state agencies, there is a strategic visioning and planning program focused on healthcare issues and the local economy that is available to rural Illinois communities. The MAPPING the Future of Your Community's Health Program allows rural communities to assess the healthcare services, the health education opportunities, and the environmental health of their area. The communities utilize this information to determine high-priority goal areas and plan for action to improve the overall health, including economic vitality, of their community.

Health care will not play the same role in every community. In some cases, it may be the dominant industry. In other cases, health care will play a minor role. The presence of a hospital is most often a major factor in the size and importance of health care in a county or region. Hospitals are the linchpin of the healthcare industry. They directly or indirectly support services such as pharmacies, physicians' offices, primary care clinics, and outpatient centers. Each community must examine the role(s) health care can play in local economic development planning.

As communities in rural Illinois face the future, the healthcare industry should play a major role in creating economic opportunities for growth and development. Although its role may differ by community, the growth of health care at the national level is not likely to slow substantially in the future. Therefore, each rural community must ask how they will garner their share of the increasing size of the healthcare expenditures This discussion should bring healthcare leaders, community officials, and business leaders together to discuss their common fates and develop forums for addressing the need to increase economic opportunity with health care playing an important role in that process.

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