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AI Could Transform Rural Healthcare, But Who Will Benefit The Most? Experts Comment



GINA MARRS
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For years, rural healthcare has sat at the centre of a quiet crisis – issues including ageing populations, staff shortages, underfunded clinics and long travel distances have created a system where access is often limited not by demand, but b geography and infrastructure.

And in less develop p between those who have and thos

Now, AI is being po ed admin and telehealth support, the promise is compelling – bring care to patients, rather than forcing patients to travel for care. In that

But, beneath that promise sits a more uncomfortable question that simply can't be ignored. If AI does transform rural healthcare, who actually benefits first? And, who risks being left further behind?

Because while, in theroy, we could achieve equiatable healthcare distribution by means of advanced technology, what's possible is not always the same as what's realistic.

Understand AI In Healthcare Matters Now

AI isn't entering a neutral environment (there's hardly any such thing as a truely neutral environment). Indeed, rural healthcare systems are already under strain, and in many cases, survival, not innovation, is the priority.

As Yahya Khan puts it, "AI can't democratise healthcare if the clinics in those communities no longer exist." Many rural practices are closing not due to lack of demand, but because of financial and administrative pressure.

That context changes everything when looking at this debate – in fact, before we even open the conversation. AI is often framed as a solution to access, but if the underlying system is fragile, introducing new technology could either stabilise it or accelerate its decline.

The Case for Optimism in the World of Modern Healthcare

There's a clear and compelling upside. AI can extend care into places where traditional systems struggle to reach.
Dan Herbatschek highlights that AI tools can provide "remote diagnostics, triage, telehealth and more," helping patients who might otherwise fall through the cracks. In areas where recruiting even a single full-time doctor is difficult, this kind of support could be transformative.

Igor Gurovich takes the argument further, noting that for many patients, the choice isn'tt between AI and a human doctor, but "AI or nothing." For isolated communities, AI may not just improve access – it may define it.

There is also a strong operational case. Administrative burden remains one of the biggest pressures on healthcare systems. Dr. Rihan Javid points to data showing that 76% of healthcare leaders report rising workloads, with backlogs across compliance, billing and documentation.

In rural settings, where staff are already stretched thin, automating these processes could free up time for actual patient care – arguably one of the most immediate and practical benefits AI can offer.

The Structural Reality

However, the idea t ıs real potential…
but it will not happe cted data. Adding
AI into that mix can

The real opportunity, he argues, lies in coordination – using AI to connect systems, streamline triage and guide patients more

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The Million-Dollar Question: Who Benefits First?

This is where the divide becomes more apparent. Larger, better-funded health systems are likely to benefit first. Sheldon Arora notes that while AI can enhance patient care, smaller facilities often lack the infrastructure, training and investment needed to implement it effectively.

Dan Herbatschek echoes this, warning that there is "a big gap" between organisations that can deploy AI properly and those that cannot. Access to the technology alone does not guarantee meaningful outcomes.

In practice, this could mean that AI initially strengthens already capable systems, while struggling rural providers fall further behind.

Less Obvious Risks To Consider

Beyond infrastructure, there are deeper risks tied to accountability, bias and liability. Neema Wasira-Johnson highlights a critical issue often overlooked in the rush to adopt AI: decision ownership. "AI won't solve access in rural healthcare if leadership hasn't defined who owns the decisions it's influencing."

In high-stakes environments like healthcare, unclear accountability can lead to delayed care, misdiagnosis or inequitable outcomes.

Kayne McGladrey raises another concern: the transfer of risk. AI vendors may provide the tools, but providers often carr legal and financial consequences when things go wrong. In already stretched rural systems, that imbalance could have s implications.

There is also the iss alities of rural patients. That incre with different health profiles.

Taken together, AI in rural healthcare looks less like a straightforward solution and more like a multiplier.

It can amplify what is already working – improving efficiency, extending reach and supporting overstretched clinicians. But it can also amplify existing weaknesses, from infrastructure gaps to financial instability and governance challenges.
The difference will come down to how it is implemented.

So, Who Wins?

The answer, for now, is mixed – there simply isn't any full-on, outright winner.

In the short term, larger systems and better-resourced providers are likely to capture the most value. They have the infrastructure, data and capacity to integrate AI effectively.

But in the long term, the real beneficiaries could be the communities that currently have no access at all – if, and only if, AI is deployed in a way that accounts for their specific constraints.

As Igor Gurovich suggests, in some cases AI is not competing with traditional care, but replacing an absence of care entirely.

The Real Issue To Consider

Ultimately, the question is not whether AI can transform rural healthcare – it clearly can. The real question is whether it will do so equitably.

Without deliberate investment, governance and system redesign, AI risks reinforcing the very inequalities it aims to solve. But with the right approach, it could become one of the most powerful tools for expanding access to care in decades.

For rural healthcare, the stakes could not be higher.

Our Experts:

Neema Wasira-Johnson: Executive Cybersecurity Advisor at Asili Advisory Group
Dr. Rihan Javid: Co-Founder and President at Edge
Tim Lawless: Global Health Lead at Publicis Sapient
Kayne McGladrey: Senior Member of IEEE
Yahya Khan: Founder and Medical Billing Specialist at Alliance Medical Revenue Group
Sheldon Arora: CEO at StaffDNA, LiquidAgents
Dan Herbatschek: CEO and Founder of Ramsey Theory Group

Igor Gurovich: Co·



AI has the potential to expand access to care in rural communities, but the conversation is missing a critical layer: **leadership accountability and decision clarity**.

Most organizations are moving quickly to deploy AI-enabled tools without clearly defining which decisions those tools are influencing, what the impact of failure would be, or who is accountable when something goes wrong. In rural healthcare environments, where resources are already constrained, the margin for error is smaller and the consequences can be more immediate.

The risk is not just technical. It's operational and human. If AI is used to support triage, diagnostics, or access pathways, a lack of clarity on decision ownership can lead to delayed care, misdirected patients, or inequitable outcomes across already underserved populations.

The organizations that will truly improve access are not the ones adopting AI the fastest. They are the ones that first define where AI should and should not influence decisions, establish clear accountability, and align those decisions to patient impact.

Without that foundation, AI may scale access but it can also scale risk.

Optional Quote "AI won't solve access in rural healthcare if leadership hasn't defined who owns the decisions it's influencing".

Dr. Rihan Javid, Co-Founder and President at Edge



“Recent data from I ling:

-76% report administrative workload has increased over the past 12 months.

“For rural communities, administrative workload and backlogs significantly strain offices and affect patients.”

Tim Lawless, Global Health Lead at Publicis Sapient



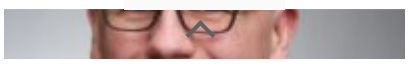
“AI has real potential to expand access in rural healthcare, but it will not happen by default.

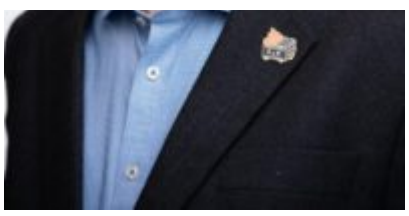
“Today’s challenge is structural. Most rural systems operate across fragmented infrastructure, disconnected data and constrained workforces. Adding AI into that environment does not automatically improve access. In some cases it can increase friction or create systems that are harder to adapt over time.

“Where we are seeing progress is in how AI connects and coordinates care. Triage, routing and workflow orchestration are starting to link together fragmented systems and guide patients to the right level of care faster. That is where access begins to improve in a meaningful way.

“AI can help close rural access gaps, but only if it is used to redesign how care operates, not just how it is delivered. The organizations that benefit will be the ones that rethink coordination, workflows and governance to make AI usable and scalable in low-resource settings.”

Kayne McGladrey, Senior Member of IEEE





“Rural healthcare is already in crisis, with nearly half of hospitals operating at a deficit. AI vendors are offering efficiency tools with purchase contracts that cap vendor liabilities at the cost of the subscription, while the provider absorbs all downstream harms, like what we saw in Delta v. CrowdStrike. In practice, this means that if an AI tool upcodes billing claims, the provider may face False Claims Act (FCA) legal risks, not the vendor. If an AI misdiagnoses a patient due to training data that is biased, the provider carries the risks of the malpractice suit – and not the AI vendor.

“AI vendors will claim that a “human in the loop” safeguard with along with a BAA and HIPAA compliance reduce these risks, but that argument collapses under the stress of a short-staffed healthcare clinic. Tired clinicians will rubber-stamp fluent, authoritative-sounding AI outputs instead of taking the time needed to validate them.

“And the odds are that the lower-cost models that rural providers can afford will have been training on data concentrated in urban centers, which under-represent rural, minority, and low-income patients who need the care the most.

“The result is a nearly complete transfer of risk: AI vendors capture revenue, providers will take on legal and financial liability, and the patients who are most at risk will bear the consequences.”

Yahya Khan, Founder and Medical Billing Specialist at Alliance Medical Revenue Group



“The industry is obsessed with AI reaching rural patients, but we’re ignoring a silent crisis: practice survival. AI can’t dem healthcare if the clinics in those communities no longer exist.

“In revenue cycle management, I see rural practices closing not because of a lack of patients, but because of financial exhaustion. They operate on small profit margins with administrative burdens that massive urban systems can absorb, b small-market practices cannot.

"The truth is, AI nee lo not have. If we do not use AI to firs e clinics, then advanced diagnost ould make things worse and accelerate the loss of rural healthcare.

Sheldon Arora, CEO at StaffDNA, LiquidAgents



"We have been staffing nurses, physicians and allied healthcare professionals in rural settings for years. From where we sit, larger health systems are likely to gain from AI tools first. For smaller facilities, investments in infrastructure, workforce and training would need to be made. AI won't democratize healthcare access in rural areas alone. Deliberate policy, investments and human support will need to happen to close the care delivery gap.

"The upside of AI in rural healthcare is evident in patient care. Remote monitoring, decision-support tools and triage systems can provide clinical expertise in places that struggle to recruit even one full-time physician. But there are risks, too. Most clinical AI platforms are trained on urban, well-resourced populations, so the potential for misfires in rural settings, where patients present later, with different comorbidities and fewer diagnostic tests, is real. Another concern could be overreliance. Thinly staffed facilities may lean too heavily on tools that still lack clinical judgment. Add in limited broadband, unclear liability and lack of regulatory frameworks and you have a fragile foundation."

Dan Herbatschek, CEO and Founder of Ramsey Theory Group



"At Ramsey Theory ılth platform Erdos Medical. We've see ns that just don't have enough healtl diagnostics, triage, telehealth, and more, benefiting the health of many who would otherwise fall through the cracks.

operational fluency.

"The enterprise healthcare systems win as the early and better funded adopters, but if there is truly to be democratized healthcare for all, systems need to be designed for all organizations, including those with limited resources, not just deep pockets. Otherwise, you're just providing rural healthcare organizations with AI systems that cannot be fully utilized."

Igor Gurovich, Co-founder and CPO at Callie Care



"Since 2010, 180 rural hospitals have closed in the United States. The question isn't whether AI will democratize rural healthcare — it's whether there is any alternative to it at all. For millions of people the choice isn't "AI or a human doctor or caregiver." It's "AI or nothing."

"Those who currently have no access to medicine will benefit the most: isolated rural seniors, sandwich-generation families, communities where the nearest specialists are hours away.

"Just as telehealth didn't "replace" rural physicians, covering gaps where no physician existed, AI tools are filling voids that workforce math makes permanent. PHI projects 9.7 million unfilled direct care vacancies by 2034, and it's a difficult to close gap.

"If we speak about the risks, they are the same as AI brings to other spheres: hallucinations, false reassurance, privacy exposure.

"And as for responsible deployment, it includes mandatory AI disclosure, strict medical guardrails, and human escalation protocols — AI should know exactly when to hand off."

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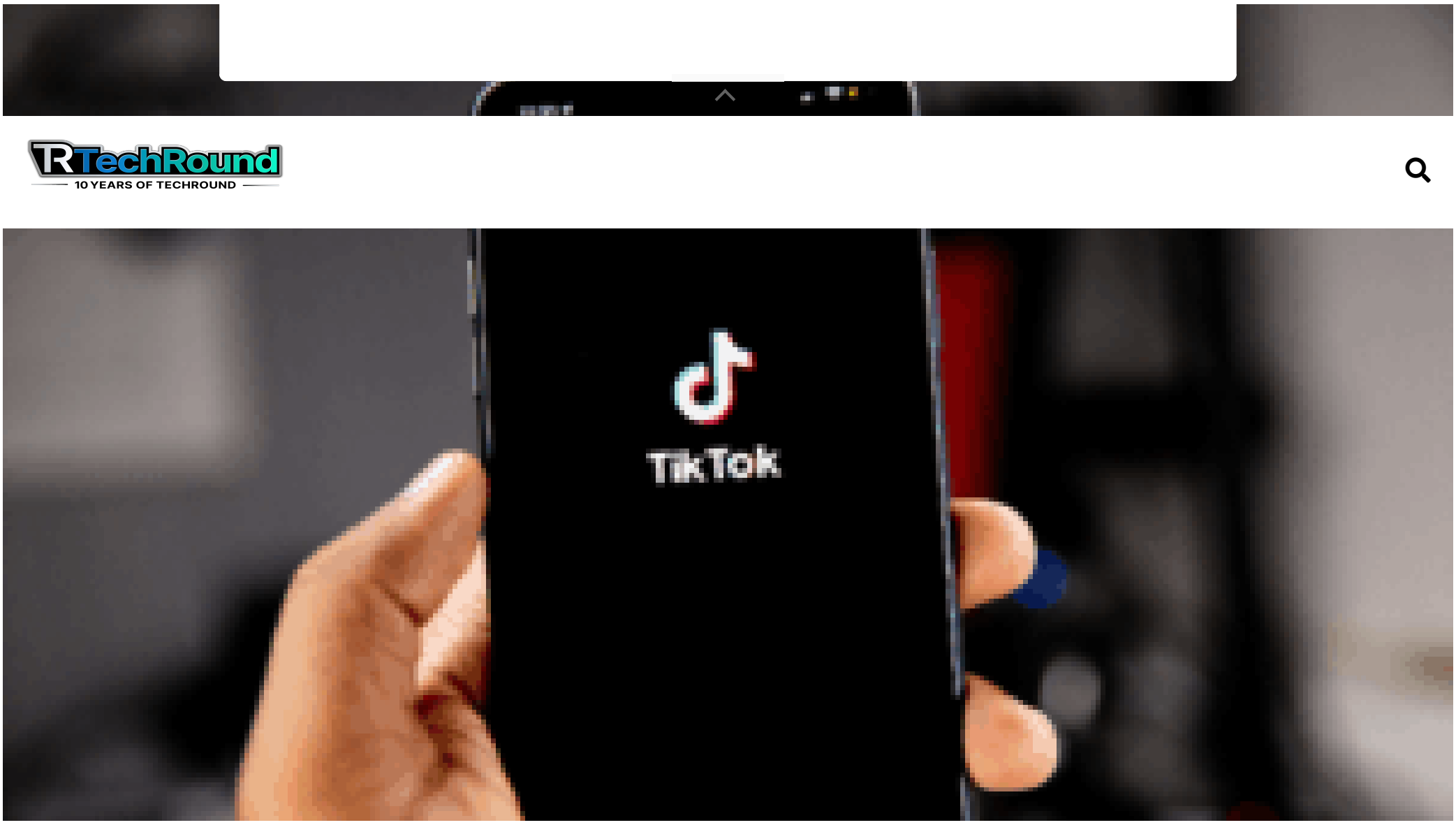
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