Tim Size

Guest Editorial

Wisconsin can prepare and support rural physicians

By Tim Size

The recently adopted Medicare "reform" bill includes significant assistance for physicians and hospitals in rural communities. For physicians there is a minimum payment update replacing a major cut, additional incentive payments for targeted underserved counties, and a floor of 1.00 in the Work Geographic Index.

While both praise and criticism of the prescription drug benefit and competitive demonstration elements of the bill have been overwrought—as befits a very partisan Congress headed into an election—the rural provisions appear to have enjoyed broad bipartisan support. Years of advocacy, better data highlighting rural problems and, more to the point, legislators from rural states who are now in leadership created a "perfect rural storm."

Does this bill provide significant help? Yes. Will it solve the current shortage of physicians practicing in Wisconsin's rural communities? No. As the dust settles, a new generation of federal issues will be identified and moved forward. But all solutions do not come from Washington, DC—there are major steps we can and must take here at home.

Over the last year, national experts have begun a debate about whether America is heading into a serious national physician shortage. However, there is no argument that Wisconsin has been experiencing a major shortage of physicians in its rural (and inner city) communities for years. The Wisconsin Office of Rural Health (ORH) lists 60 federal Health Professional Shortage Areas, all but a handful of which are rural. Given the graying of the physicians currently working in rural Wisconsin communities, the shortage will get worse before it gets better without a concerted statewide effort.

Below are what I believe are several key building blocks for a comprehensive statewide strategy.

Medical Education

The attributes of medical students and programs that lead to graduates choosing family medicine and other specialties for rural practice are well known. One of many articles on the topic is by Howard K. Rabinowitz, MD, and colleagues.[1] They indicate the critical importance of a strong institutional mission (not just lip service), a focus on primary care, targeted selection of students, early clinical experiences and community-based training outside the institution.

Neither our state nor our medical schools have committed to specific targets regarding the proportion of their graduates who will choose to practice in rural and other underserved Wisconsin communities. To deny the role of the medical school admissions process, faculty attitudes and off-campus training experiences in affecting where graduates choose to practice is to deny a wealth of published research to the contrary. Bottom line, it's hard to hit a target we haven't set.

We must develop a public-private sector "agency" in Wisconsin that has the primary responsibility of keeping physician shortage and distribution planning in the limelight and that serves as a forum for tracking the progress, or lack of progress, being made towards meeting physician supply and distribution targets.

No discussion about the future of Wisconsin is complete without reference to the "Blue Cross Monies"—truly, never have so few (dollars) been called upon to serve so many. The transfer of funds to our two medical schools following the Blue Cross/Blue Shield conversion to a for-profit entity will fund new community initiatives across the state, but most dollars will be spent within the two schools. Even then, while the annual monies that will be available are significant, they are small compared to the overall budget of each school. A realignment of the schools, as a whole, will ultimately have a far greater impact than any direct expenditures of Blue Cross dollars. In my opinion, one reason to be cautious is that both medical schools have been left largely unchanged by tens of millions of federal Area Health Education Center dollars.

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The public and community health oversight and advisory committees at each school have the levers to fundamentally transform both schools; whether they choose to do so remains to be seen.

Health Plans

The medical imperative, "First, Do No Harm" must be respected at the regional level if it is to survive within local practices. We are beginning to see communities being undermined with the following situation: An individual must travel significant distances to find work and his or her employer offers only one health insurance option with a defined network that includes providers local to the place of employment but not the commuter's home. Providers in the employee's home area are not allowed to serve these individuals, even when they are willing to accept terms (financial and quality accountability) comparable to other contracted providers. The law and code is clear, but the enforcement of fair guidelines is not.

Building and sustaining effective systems of care in local rural communities is a challenge on the best of days; it does little good to improve Medicare payments, modernize medical education, then look the other way when some health plans engage in selective contracting processes that have the effect of undermining local infrastructure by prohibiting patients from using local physicians. The irony of excluding physicians from defined networks in rural parts of the state is that even if the supply of physicians in the affected communities can be increased, local residents and employers will experience a decrease.

Community Systems

Those of us working at the local level have the greatest responsibility. Local health care "systems" are very complex entities, whether corporate or virtual, locally owned or part of regional corporations. But all are like large extended families that are capable of both fantastic teamwork and incredible dysfunction. As with most families, the fights are usually over egos and money; healthy families and healthy systems know one member cannot be advantaged at the expense of another—it is the job of both physicians and lay leadership to find the common ground.

There is much local physicians and communities can do; the following is taken from *Physician Recruitment and Retention*:[2]

> "The retention of a physician in a community is dependent on the perception of that physician that his or her life needs have been satisfied. (Beyond financial remuneration), these perceived needs may be divided into professional fulfillment and lifestyle."

Professional Fulfillment

- "Decrease professional isolation by supporting tele-informatics and outreach education programs of states and by the use of non-physician providers.
- Identify care needs at the community level. Use state and federal funds to assist rural hospitals and clinics where access to care would be threatened by hospital closure and physicians would be further deprived of opportunities to utilize their professional skills.
- Develop and use innovative delivery systems that emphasize coordination and cooperation among providers, institutions and communities."[2]

Lifestyle

- "Support initiatives to offer locum tenens to rural practitioners that would be available on a periodic basis for purposes of continuing medical education or family vacations.
- Develop programs for support of the physician, spouse and children of the physician. This should include work and social opportunities for the spouse and family.
- Work to create innovative plans to share the workload through aggressive network building, partnering over distances, and sharing of resources."[2]

Summary

The Institute of Medicine of the National Academies in its November 2002 report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, gives the best vision for American health care I have yet come across.

> "The health care system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal health care with broader community-wide initiatives that target the entire population. The health care system must have well-defined processes for making the best use of limited resources."

It is our job in Wisconsin to assure that we have "well-defined processes for making the best use of limited resources" for preparing and supporting physicians in rural communities.

References

1. Rabinowitz, H, Diamond, J, Markham, F, Paynter, N. Factors for designing programs to increase the supply and retention of rural primary care physicians. *JAMA*. 2001;286:1041-1048.
2. *Physician Recruitment and Retention. An Issue Paper.* Prepared by the National Rural Health Association—November 1998.

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