

Review & Commentary on Health Policy Issues from a Rural Perspective-April 1st, 2000

Medicare Fairness Rebellion Spreads

In a manner similar to the early days of the states' taking on the tobacco cartel, Wisconsin has become the second state to file a suit challenging the inequitable geographic variation in Medicare payments and benefits. After months of detailed and technical preparation, Wisconsin's Attorney General Jim Doyle filed a lawsuit in U.S. District Court on March 15th to force the federal government to change the formula it uses to calculate payments to HMOs that serve senior citizens under Medicare. Wisconsin will also be filing an amicus brief on behalf of the Medicare Justice Coalition's case filed in Minnesota last November.

"The federal payment system is unfair to Wisconsin senior citizens, who paid just as much in Medicare taxes during their careers as did elderly residents in other states," Doyle said. "It is unacceptable that the federal government is subsidizing expensive health care benefits in some parts of the country while senior citizens in other areas are forced to choose between buying food and buying the medications they need to stay alive."

The lawsuit also alleges that the payment disparities not only harm individual senior citizens, but also burden the state government by shifting costs to Wisconsin's Medical Assistance program. The complaint alleges that if the HMO reimbursement and en-

rollment rates in Wisconsin were equal to those in the highest reimbursement states, Wisconsin would save \$24 million annually in Medicaid expenditures.

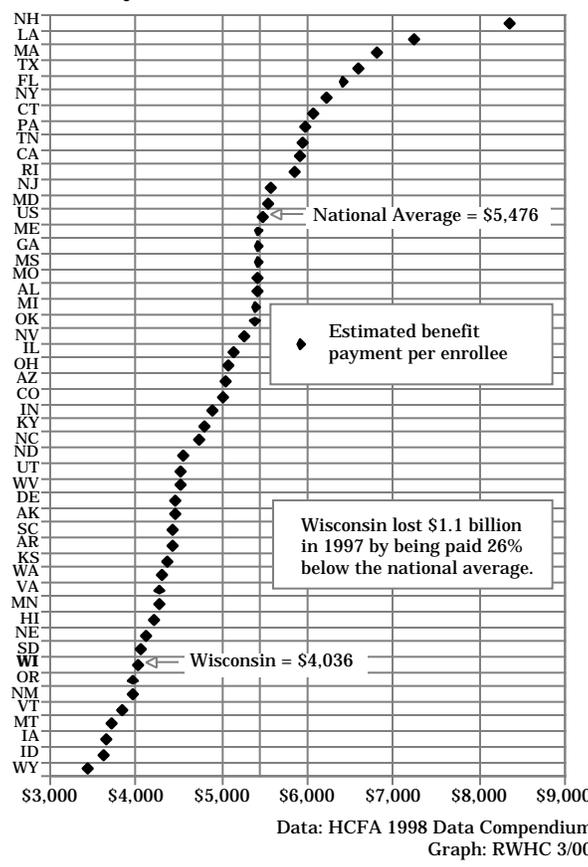
The complaint alleges that the federal formula is flawed because it bases HMO payment rates on past Medicare spending in different regions without adjusting for local variations in spending that are not related either to the medical needs of the senior citizens or to the local price of needed services. As a result, HMOs in areas with excessive spending due to local waste and inefficiency receive a higher payment to HMOs in regions that have kept health care spending under control.

An update from the Medicare Justice Coalition:

"The Medicare equity lawsuit filed by the Medicare Justice Coalition (MJC) and Minnesota Senior Federation-Metropolitan Region, with the Minnesota Attorney General's lawsuit, against the federal government is progressing. The suit was filed Nov. 17 and the government, as expected, asked for dismissal of the suit Jan. 18. The Federation and the Minnesota attorney general filed a 'foot-thick' comprehensive rebuttal on Feb. 9. MJC expects preliminary hearings on the bill to be held in U.S. District Court in Minneapolis late this spring or early summer."

"Grassroots organizing is expanding with consumer and provider groups from Oregon, California, North Dakota, Iowa, South Dakota and Wisconsin joining the MJC. Trips

Medicare Program Payments per Enrollee in 1997 by State of Residence



by MJC staff and leaders have taken place to both Oregon and Iowa in the last few weeks to solicit support for the Medicare Justice Campaign. Further contacts in Maine, Pennsylvania, North Carolina and other areas are being made. Legal briefs in support of the Senior Federation's and the Minnesota attorney general's Medicare equity lawsuit are now being considered in as many as 17 states either by state governments or consumer organizations. These 'friend of the court' briefs are expected to be filed within 60 days."

"More than 600 people have joined the Medicare Justice Campaign. It's easy to do and Federation membership is not required. Go to update www.mnseniors.org or call 651/645-0261 ext. 179 or toll free, 877/645-0261 ext. 179. Follow the prompts and you will be added to the Medicare Justice Campaign membership and receive background on the issue, updates and ways you can help solve the problem."

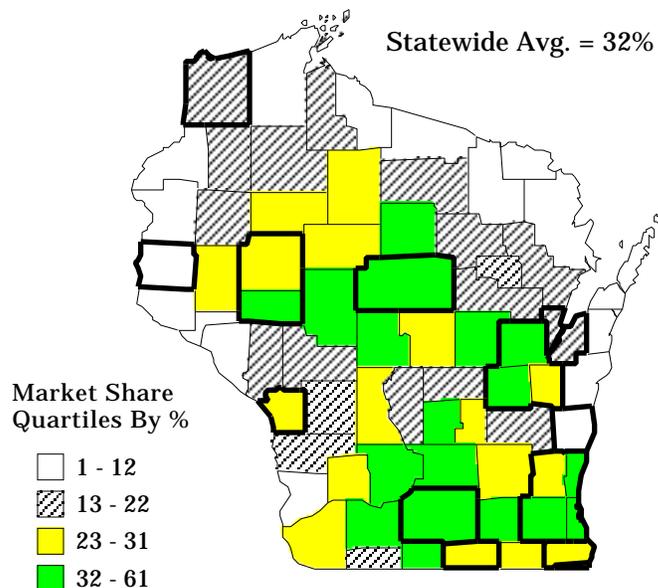
HMOs, Other Plans, More Alike Than Not

From a Press Release "National Survey Comparing HMOs To Other Plans Finds Few Differences In Service Use" from The Center for Studying Health System Change < www.hschange.com>, 3/9/00:

"The Center for Studying Health System Change (HSC) has released a new study comparing HMOs to other insurance plans on 55 key indicators related to access, service use and satisfaction. The study shows that consumers in HMOs are as likely as those in other plans to be hospitalized, to undergo surgery, and to visit the emergency room and no more likely to report access problems. At the same time, the study also points to important differences, both positive and negative, between HMOs and non-HMOs that imply that consumers face trade-offs when they are choosing between types of plans."

"The study is based on HSC's 1996-1997 Community Tracking Study Household Survey, which includes nearly 36,000 respondents who have commercial insurance. 'This comprehensive comparison of HMOs to other plans offers objective, timely information to policymakers,' said Peter Kemper, Ph.D., HSC vice president and study co-principal investigator. 'While the overall findings may be welcome news for those worried that HMOs unnecessarily restrict access to care, they raise questions about HMOs' longer term ability to control costs.'"

HMO Rural Market Share as of 1/99



Percentages use '90 census; enrollment as of 1/99. Includes data from separately licensed HMOs only. Percentages include enrollees in both closed panel and point-of-service plans.

Urban Counties (MSAs) are shown with black lines.

Data: WI OCI for 9/99
Graph: RWHC 3/00

"With respect to costly services the only area where there was a difference between HMOs and other plans was in the use of specialists. Contrary to conventional wisdom, there is no greater use of outpatient surgery in HMOs than in non-HMOs, and hospital stays and number of surgeries per 100 enrollees is nearly identical. In addition, consumers in HMOs are only slightly more likely to report that they did not get care they thought they needed."

"In other areas, consumers face trade-offs when choosing between an HMO and other kinds of plans. While consumers enrolled in HMOs receive more ambulatory and preventive care, they receive less specialist care. Specifically, 25 percent of those enrolled in HMOs saw a specialist on their last physician visit as compared to 30 percent of those in other plans."

"Not surprisingly, consumers find HMOs to be less costly. Specifically, 10 percent of families enrolled in HMOs paid more than \$1,000 per year in out-of-pocket expenses as opposed to 17 percent of families in other plans paying that amount. Consequently, those in HMOs are less likely to report that financial barriers get in the way of receiving needed care than their counterparts in other plans. However, consumers en-

rolled in HMOs were more likely to report that they faced administrative barriers.”

“ ‘All types of plans seek to limit use of services, but their methods differ,’ said James Reschovsky, HSC senior health researcher and study co-principal investigator. ‘HMOs use administrative and financial incentives targeted at providers, such as controls on referrals to costly specialists, while non-HMOs make greater use of cost sharing, such as high co-payments, to limit use of services.’ ”

“ ‘Although there has been some blurring in the marketplace, this study indicates that distinctions continue to exist between HMOs and other kinds of plans,’ said Paul B. Ginsburg, Ph.D., HSC president. ‘These kinds of trade-offs suggest that consumers will be best served if they have a choice between types of plans. At the same time, an expansion in choice is not without its costs.’ ”

“The study also shows that consumers in HMOs assess the care they receive less positively than those in other kinds of plans. On eight out of nine satisfaction measures, consumers rated their care lower in HMOs, with differences ranging between 3 and 7 percentage points. Those in HMOs were less likely to trust that their doctor would put their medical needs first and refer them when needed to a specialist; they also rated their care less positively with respect to physicians listening to them, providing explanations and giving them a thorough exam.”

Elderly Dig Deep To Pay For Medical Care

From “Study Finds Elderly Americans Spend 19% of Income on Healthcare” at the Journal of Gerontology/MedscapeWire < /www.medscape.com>, 3/3/00:

“Senior citizens who need healthcare the most can least afford it, and they face the greatest burden of out-of-pocket expenses for medical care, according to a new study published in the forthcoming issue of the Journal of Gerontology.”

“Elderly Americans spend on average 19% of their total income on out-of-pocket medical expenses annually, with more than half of these payments going toward prescription drugs and dental care. Out-of-pocket expenses include insurance premiums, medical co-payments, and prescriptions.”

“ ‘Nineteen percent is fairly burdensome for the average elderly person, but the figures are even worse for

those in the lowest income levels, for those with chronic health problems and for the oldest of the old,’ said lead author Stephen Crystal, chairman of the Division on Aging of the Institute for Health, Health Care Policy and Aging Research at Rutgers University.”

“According to the study, the most vulnerable are:

- Those in the lowest-fifth income level (up to \$6,720 per capita family income), who spend 32% of their income, despite Medicaid coverage for some, compared with those in the top tier, who pay less than 9%;
- Those whose self-reported health status was ‘poor,’ who spend 29% vs. those in “excellent self-reported health, who spend 15%;
- Those aged 85 years and older, who are paying 22% vs. those aged 65 to 74 years, who paid 17% in total out-of-pocket costs for healthcare;
- Those who did not complete high school, who spend 21% compared with 12% for college graduates.”

“According to the study, prescribed medication costs have grown to account for 33.9%, more than one-third, of the elderly's overall all out-of-pocket payments to healthcare providers. The share is even higher — 40% — for those in the lowest two-fifths of income (below \$9384 per capita family income). Medicare does not cover most outpatient prescription drug costs. Dental services, which are not covered by Medicare and

The Rural Wisconsin Health Cooperative, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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rarely covered by most insurance plans, accounted for 18% of expenses.”

“The cost burden is also affected by the type of insurance coverage an elderly person has. Those with self-purchased supplemental insurance spent 25% of their total income, while those relying solely on fee-for-service Medicare spent 23%. The lowest cost burdens were associated with employer-sponsored coverage, which averaged 16%, and health maintenance organizations (HMOs), which ranged between 14% and 15% of income.”

“In our sample of older people in the community, Medicare covered only 65 percent of payments to health care providers (doctors, hospitals, pharmacies) leaving more than one-third of health care expenses uncovered. Although private insurance and Medicaid paid for some of the uncovered expenses, private insurance is often costly and Medicaid was available to only the poorest elderly. This leaves 15 percent of older people's expenditures to be covered out-of-pocket,’ explained Crystal. ‘Expanded supplemental coverage through Medicaid could help fill these gaps for the low-income elderly.’ ”

“The study takes a comprehensive look at out-of-pocket medical expenses that different groups of elderly people are facing and the factors, such as health, age, and education, can influence the medical financial burden.”

“What this study reveals is that despite Medicare, the elderly are exposed to substantial out-of-pocket health-care expenses, particularly in the area of prescription drugs,’ noted Crystal. ‘As Medicare reform proposals

are considered, it's important to know how proposed changes will impact those elderly who need health care the most, such as the chronically ill and the near poor. These are the individuals who are most heavily burdened and have a pressing need for subsidized prescription drug coverage. We need to bring this information to the forefront to protect the health and well being of our most vulnerable elderly citizens,’ he added.”

Popular Perception Wrong Re Drug Costs

From the Press Release “Volume, Not Price, Is Primary Driver Of Higher Drug Spending” from the MEDSTAT Group <<http://www.medstat.com>>, 3/6/00:

“The increased use of medicines, not rising prices, is the cause of higher prescription drug spending, according to new research released in *Health Affairs*, a leading health policy and research journal.”

“Two of the nation's top healthcare research firms, Protocare Sciences and The MEDSTAT Group, co-authored this new study. ‘In this paper we examined the price and volume drivers that influence the growth in spending on prescription drugs. We found that the causes of these increases are more involved than the popular story of price hikes and consumer-oriented advertising,’ said Robert Dubois, M.D., the study's lead researcher and chief executive officer, Protocare Sciences.”

“Increased volume, not price, played the dominant role for seven of the fastest growing, highest spending drug categories,’ according to Anita Chawla, Ph.D., director, outcomes research at MEDSTAT. ‘The categories studied include treatments for asthma, depression, diabetes, high cholesterol, allergies, gastrointestinal problems, and hormone replacement.’ ”

“On average, volume increases outweighed price increases by 5 to 1. Typically, volume increases were driven by more patients, more prescriptions per patient, and more days of therapy for the seven chronic diseases studied. The authors' broad definition of price included not only price inflation but also the effects of any shifts to newer medicines. The study found increases in drug category expenditures ranging from 43 percent to 219 percent over a three-year period (1994-1997 or 1995-1998).”

“New scientific knowledge enables doctors to identify patients at higher risk, diagnose them more accu-



rately and earlier, and more effectively treat the diseases found,' said Dr. Dubois."

" 'Medical science has made tremendous gains in effective treatments for patients with chronic disease, and more patients are receiving what science has proven to be effective,' Dr. Dubois continued. 'In the health plans we studied, a greater percentage of their patients received, for example, cholesterol lowering or hormone replacement therapy. Translating new science into routine practice means better care for patients.' "

"Dr. Dubois concluded that, 'New science, better medical practice, and identifying more patients with chronic disease, not surprisingly, increase prescription volume and may further fuel total drug spending.' "

"The MEDSTAT Group is a healthcare information company that helps its clients manage the cost, quality, and strategic positioning of health services and benefits. Its nearly 1,000 clients include some of the nation's largest corporations, health plans and insurance companies, providers, pharmaceutical companies, and federal and state government agencies. Protocare Sciences, a division of Protocare, Inc., has expertise in disease management products and services, health services research, healthcare analysis, and outcomes assessment. Protocare Sciences is headquartered in Santa Monica, Calif."

"The study was funded by the National Pharmaceutical Council, a research and educational organization whose members are leading pharmaceutical companies."

Lifestyle Enhancement Or Basic Healthcare?

From "The Economics Of Viagra, A New Blockbuster Drug Raises Important Questions About What Is Viewed As 'Medical Necessity' By Insurers" by Alison Keith in *Health Affairs* - March/April 2000:

"Can insurers' desire not to cover Viagra be traced to their desire to exclude it because it is merely a 'lifestyle enhancement' and not a treatment for a real

**WISCONSIN RURAL HEALTH ASSOCIATION
ANNUAL CONFERENCE, APRIL 27TH-28TH
HOTEL MEAD, WISCONSIN RAPIDS**

This year's keynoter is Tom Ricketts, author of the recently published rural health "bible," *Rural Health in the United States*. Tom is hands-down one of our most humorous story tellers, rarely allowed out of North Carolina, let alone into Wisconsin. To receive a conference registration packet, email Barb Duerst at the WI Office of Rural Health, <bduerst@facstaff.wisc.edu>.

medical condition? To an economist, this explanation also has a hollow ring. A bit of thought reveals that the distinction between lifestyle and medical necessity is arbitrary at best."

"In many forums, the coverage debate has turned squarely on the questions of what treatments are or should be considered medically necessary. The

State of California stated, in its opposition to Kaiser's original decision not to cover Viagra, that its insurance regulations require insurance to cover medically necessary goods and services and to provide health coverage to patients 'unhindered by a plan's fiscal concerns.' In addressing this issue in a class-action case, an attorney asked, 'Is sexuality a mere 'convenience' or a vital human function?' He noted that since health insurance providers had 'historically provided unlimited coverage for more invasive and painful but equally expensive treatments for impotence,' the decision not to cover Viagra was driven by financial considerations."

"One can easily argue that Viagra is a medically necessary treatment. Erectile Dysfunction (ED) is a prevalent condition that interferes with an important component of human health. The impact of ED extends beyond sexual activity itself. Anger, depression, and anxiety resulting from ED can impair the quality of life of both affected men and their sexual partners and can cause harm to personal relationships. Also, patients assess ED as a serious health condition. At a meeting sponsored by the World Bank at the World Health Organization in 1995, attendees were asked to rank the average handicap stemming from a variety of conditions. ED was ranked similarly with infertility, rheumatoid arthritis, and angina."

"The debate over 'lifestyle' conditions and treatments is really a reflection of a larger question of the continuum from immediately life-saving treatments to those that make life more pleasant by improving health-related quality of life. The apparently easy distinction between conditions that affect real health and those that merely affect lifestyle is, in fact, arbitrary. Certain activities-in this case-, sex-are viewed by some as personal options that are not inherently part of the definition of good health and therefore should not be included in health insurance. Cosmetic improvements such as baldness remedies, weight-loss

programs, and cosmetic surgery, are included in this bundle.”

“However, the same options apply to a wide range of medical conditions that are commonly considered legitimate health concerns. On one end of the spectrum, treatment for smoking cessation may be considered a lifestyle issue; in fact, quitting smoking is one of the most benefi-

cial things that one can do to improve one’s long-term health prospects. One could also argue that treatment for arthritis or migraines primarily affects lifestyle and not the ability to survive. In the extreme, one might argue that recent innovations in the treatment of stroke are principally lifestyle enhancements, aimed at preventing a lifestyle burdened by immobility or other lost functions. The point, of course, is that virtually all medical treatment affects patients’ ability to live the lives they prefer. There is simply no bright line distinguishing lifestyle from medical necessity.”

“An arbitrary distinction between health and lifestyle will be increasingly out of place as chronic conditions come to the fore with increasing prevalence, as populations age, and as new technologies emerge to treat or manage these conditions. If these new technologies are to be allowed to provide the benefits they promise, insurers must do a better job of aligning coverage decisions with their members’ true valuation of the benefits—that is, their willingness to pay.”

Strong & Stoic Can Be Bad For Your Health

From the press release “Many Men Dangerously Out Of Touch With Health Care” from The Commonwealth Fund <www.cmwf.org>, 3/14/00:

“New research shows that an alarming portion of American men fail to get the medical care they need to stay in good health. A significant number of men do not get routine checkups, preventive care, or health counseling, and many ignore symptoms or delay seeking medical attention when sick or in pain. “This research dramatizes the need for efforts to address

**NATIONAL RURAL HEALTH ASSOCIATION
ANNUAL CONFERENCE, MAY 24-26, 2000
HYATT REGENCY HOTEL, NEW ORLEANS, LA.**

New Orleans, LA., will host as members and other participants gather for the learning and networking experiences of "NRHA 2K: À bonne santé! (To good health)." Following the successful three-day format of last year's event, the conference will run Wednesday, May 24, through Friday, May 26, 2000, allowing attendees to take in the sights of New Orleans during the Memorial Day weekend. Visit www.nrharural.org for more information.

men’s special health needs,’ said Karen Davis, president of The Commonwealth Fund.”

“ ‘Society’s demand that men be strong and stoic can be harmful to their health if it causes them to ignore what their bodies are telling them and avoid seeking needed medical care,’ said David Sandman, program officer at The Commonwealth Fund and lead author of the

study. ‘Men have a shorter life expectancy than women and suffer higher mortality rates from the leading causes of death. Strengthening men’s connections to the health care system and sensitizing physicians to male health concerns could bring about improvements in men’s longevity and well-being.’ ”

Giant, Competing Businesses Network

From “Three Carmakers Create Online Network” by James R. Healey in *USA TODAY*, 2/28/00:”

“Three big automakers, prodded by their suppliers, set aside old and fierce rivalries, downsized executive egos and crafted a cost-cutting network in less than two weeks that has breathtaking financial potential.”

“General Motors, Ford Motor and DaimlerChrysler—the heart of the old, bricks-and-mortar economy moving at dot-com speed – are merging their individual Internet purchasing operations into a single Web link available to suppliers, dealers and even other automakers.”

“The new network will encourage fierce bidding among worldwide suppliers, slicing the cost of everything from huge factory machines to dealership shop rags. That should keep car prices down and profits up. The venture could slice \$50 billion a year from the nearly \$250 billion the three automakers spend on parts and supplies.”

“The auto network is a big signal that old-economy rivals can and will find new-economy ways to cooperate when it saves time and money.”

“Major airlines are setting up a cooperative Web site that lets fliers shop for fares directly. Chemical and

oil-drilling industries likewise have such so-called business-to-business, or B2B, Internet exchanges.”

“The American Society of Travel Agents asked the Justice Department this month to investigate the airlines’ site for antitrust violations. That seems the exception. ‘Typically, these things can be structured to avoid antitrust problems,’ says William Baer, former Federal Trade Commission antitrust chief.”

Value Of Hospital Systems Questioned

From “Does System Membership Enhance Financial Performance in Hospitals?” by D. Tennyson and M. Fottler in *Medical Care Research and Review*, 3/00:

“While hospitals continue to join multi-institutional systems (*central ownership*), data on the benefits of system membership are ambiguous. This study examined 166 Florida hospitals in 1986 and 1992. System membership, in general, did not enhance financial returns for the pooled data for either year.”

“It is possible that hospital executives are unaware of systems to enhance financial performance. They assume they are acting rationally by joining systems to enhance financial returns. It is possible that systems do achieve economies of scale, but these are offset by high transaction costs or insufficient or poor managerial implementation. That is, the costs of communications, contracts, bureaucracy, and paperwork associated with system membership may offset the economic benefits of economies of scale. In addition, the higher debt loads associated with system hospitals may lower their returns.”

Bureaucracy Knows No Geography

From *The Book of Embraces* by Eduardo H. Galeano:

“In the days of the military dictatorship, in the middle of 1973, a Uruguayan political prisoner, Juan Jose Nouched, received a five-day punishment: five days without visitation rights or exercise; five days without anything, for having violated the rule. From the point of view of the captain who imposed the punishment, the rule left no room for argument. The rule clearly established that prisoners must walk single file with both hands behind their backs. Nouched had been punished for putting only one hand behind his back. Nouched was one-armed.”



“He had been taken prisoner in two stages. First his arm was taken. Then he was. His arm was taken in Montevideo. Nouched was escaping as fast as his legs could carry him when the policeman chasing him managed to grab him and shout: ‘You’re under arrest!’ and found himself holding the arm. The rest of Nouched was taken a year and a half later, in Paysandu.”

“In prison, Nouched wanted his lost arm back: ‘Fill out a request form,’ they told him. He explained that he didn’t have a pencil: ‘Fill out a request for a pencil,’ they told him. Then he had a pencil, but no paper: ‘Fill out a request for paper,’ they told him. When at last he had pencil and paper, he wrote out a request for his arm.”

“Eventually, he got an answer. No. It wasn’t possible: his arm was under a different jurisdiction. He had been tried in a military court. His arm had been tried as a civilian.”

* * *

“Sixto Martinez completed his military service at a barracks in Seville. In the middle of the courtyard of that barracks was a small bench. Next to the small bench, a soldier stood guard. No one knew why the bench had to be guarded. The bench was guarded around the clock, just because: every day, every night, and from one generation of officers to the next the order was passed on and the soldiers obeyed it. No one expressed any doubts or ever asked why. If that’s how it was done, and that’s how it had always been done, there had to be a reason.”

“And so it continued until someone, some general or colonel, wanted to look at the original order. He had to

rummage through all the files. After a good deal of poking around, he found the answer. Thirty-one years, two months and four days ago, an officer had ordered a guard to be stationed beside the small bench, which had just been painted, so that no one would think of sitting on the wet paint."

Seinfeldists Develop Academic Discipline

From 'A Mundane Manifesto' by Wayne Brekhus in the inaugural issue of *Journal of Mundane Behavior* <www.mundanebehavior.org>, 2/00:

"This mundane manifesto calls for analytically interesting studies of the socially uninteresting. I argue that the extraordinary draws disproportionate theoretical attention from researchers. This ultimately hinders theory development and distorts our picture of social reality. This manifesto paves the way for an explicit social science of the unmarked (mundane). It is hoped that a similar manifesto can be written for the humanities. After articulating the empirical, moral, and theoretical foundations of interestingness, I outline four methodological strategies for an exciting social science of the mundane. These strategies are 1) reversing conventional markedness patterns to 'analytically mark' the socially unmarked, 2) marking everything with equal analytic ornamentation, 3) universalizing from the marked to develop general social theory, and 4) developing an 'analytically nomadic' sensibility."

American Healers In Need Of Healing

From "Waving Goodbye To Healthcare" by Leland R. Kaiser in *Modern Healthcare*, 2/28/00:"

"A small but significant exodus from healthcare is under way. The exodus is not about losers. The folks who are leaving represent many of our best and brightest performers. The usual villains blamed for the changing fortunes of healthcare include the Balanced Budget Act of 1997, the rise of managed care, increasing competition, declining Medicare payments, slow third-party reimbursement, unsuccessful consolidations and mergers, and the burden of meeting ever-more-stringent requirements of regulatory and accrediting agencies."

"Undoubtedly all of these play a role in our plight. However, an even more insidious factor may be in-

volved: the amount of time and energy it takes to do the job. An executive's family and personal life suffer under the crushing load of just staying even with the game. Work weeks of 70 to 80 hours are not uncommon among top-level corporate managers. The question is, how much of your life do you want to sacrifice to stay afloat in this industry?"

"How do we put joy and meaning back into the lives of folks who work in healthcare? Two approaches are possible. The first is rather daunting. It requires a restructuring of the industry. This involves major political, social, and economic design challenges, but they're issues that must be addressed as we move into the new century. The second approach, which offers more near-term relief, is to provide renewal and regeneration for healthcare professionals, enabling them to survive-and maybe even thrive-in a chaotic, high-stress environment."

"At the Kaiser Institute, we are working on both approaches. We promote the idea of collaboration rather than competition among local healthcare providers. We believe government, the marketplace and the voluntary sector must come together in every community in a shared covenant to serve everyone."

"The institute emphasizes spirituality-a missing ingredient in contemporary healthcare. The institute's Fellowship in Intuition teaches healthcare managers to use the right side of the brain to envision and create abundant communities where all healthcare providers work together. On the right side of the brain are love, compassion and nurturance-also in short supply in healthcare. A new mental model is needed to change the world of healthcare. Until that model is in place, no amount of effort, time or money will solve the problems the industry faces today."

