

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

Local Health Care Strengthens Communities

From the soon to be published "The Economic Value of the Health Care Industry In Sauk County, Wisconsin" by Albert Lanier and Ron Shaffer, Center for Community Economic Development, University of Wisconsin-Extension, a collaborative effort with the Sauk County Development Corporation, the three Sauk County hospitals, RWHC, the Southeast Wisconsin Area Health Education Center and the Wisconsin Network for Health Policy Research, 7/00:

"This study evaluates the importance of the health care industry on the economic well being of Sauk County, Wisconsin. It is estimated that the health care industry alone currently employs 2,907 people and generates \$160 million in total annual revenues and \$85.2 million in personal income. When taking into account the relationship between the health care industry and the rest of the county economy, the importance of the health care industry is much greater than the above base estimates."

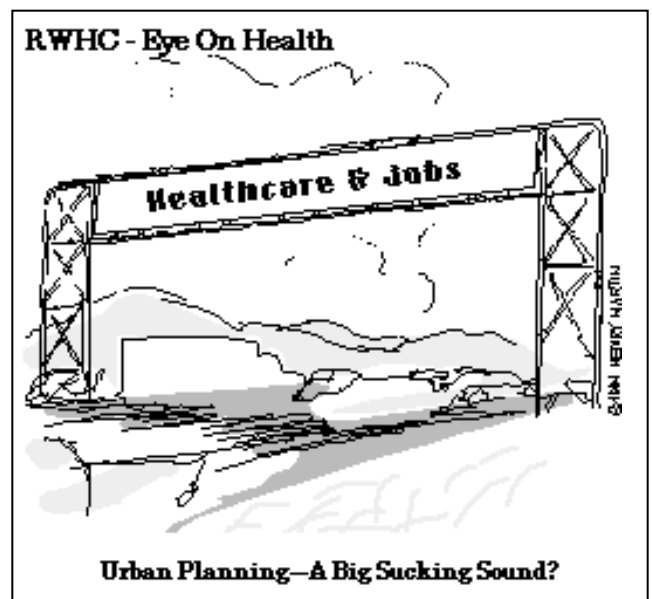
"Sauk County hospitals have been able to serve a large segment of the market for Sauk County patients with 66 percent of Sauk County inpatients using local inpatient services and 71 percent of outpatients using local outpatient services."

- "Every 2 dollars of revenue generated by the health care industry will generate an additional dollar of revenue in other Sauk County industries."
- "Every two jobs created (or lost) in the Sauk County health care industry will cause the number of jobs in other industries to increase (or decrease) by one job."
- "Every 1 dollar of personal income created in the Sauk County health care industry creates 30 cents worth of personal income in other county industries."

"The analysis presented in the study concludes that Sauk County's health care sector is strong and vibrant despite changes in the statewide health care system structure over the past few years such as the emergence of managed care as a dominant force in rural areas. We can see that changes in the local health care delivery system affect not only the quality of life for local residents but also have county wide economic implications."

"The study provides evidence to show that the Sauk County economy depends a great deal on the strength of its health care sector. It is necessary for local decision makers to consider how decisions in the health care sector may influence the presence of other industries in the county. A better understanding of these changes will allow the county to better plan for changes in the health care sector, maximizing the positive impacts of these changes and minimizing negative ones."

"While many people think of the health care sector as an ancillary sector that augments other parts of the economy, it is much more. It is also an economic base



sector that provides jobs and serves as a growth engine for the local economy. We have estimated that the health care industry, with its linkages, accounts for 4,376 jobs in Sauk County, 11 percent of the total jobs in the county. The hospital sector makes up more than a quarter of these jobs which makes it a very important force in the county economy. Furthermore, every two new health care jobs created will create one additional job elsewhere in the county. The converse is also true, a loss of two jobs in the health care sector would mean that another job would be lost in another industry within the county.”

“Moreover, the health care sector generates \$127 million in personal income, or approximately 12 percent of the county’s total personal income. Every dollar of personal income generated directly by health care has an additional effect of creating 30 cents of personal income in other industries. Given these numbers and what they represent to the Sauk County economy, it is imperative that local officials think of the health care sector not just in terms of how it affects the health of its citizens but also how it affects the economic structure of the economy.”

“Making the public aware of the importance of a strong local health care sector by encouraging use of local hospital and health care facilities when possible will ensure that Sauk County’s health care sector remains strong for many years to come.”

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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For a free email subscription, send an email with “subscribe” on the subject line. Due to staff hiking/consulting this August in rural Washington (the state of), the next issue Eye On Health issue will be distributed in late September.

Medicare Justice Will Take a Bit Longer

From a *Press Release* by the Minnesota Senior Federation, 7/7/00:

“United States District Court Judge Donald D. Alsop has dismissed a lawsuit filed November 17, 1999 by the Minnesota Senior Federation, Metro Region, and Minnesota Attorney General Mike Hatch against the United States of America and Secretary of Health and Human Services Donna E. Shalala, alleging discriminatory Medicare rates. While Judge Alsop reached his conclusion because he believes the Medicare case does not violate the Constitution, he had strong words for Medicare’s inequities and recognizes the need for new Congressional legislation soon.”

“The court’s decision ‘is not to be considered a judicial endorsement of a reimbursement system which even the defendants concede results in gross unequal treatment of senior citizens,’ said Judge Alsop. ‘It is to be hoped that those with ultimate authority to remedy this wrong--indeed those who created it--will promptly recognize the injustice they have created and enact legislation to correct it.’”

“ ‘We consider the dismissal a temporary setback, but Judge Alsop’s comments have unquestionably reinforced the need to push forward and to continue to organize consumers nationwide to, as Judge Alsop suggests, change legislation and correct the unequal treatment of seniors,’ said Peter Wyckoff, executive director of the Minnesota Senior Federation, Metro Region. Wyckoff said that the Federation’s efforts will probably include an appeal. The Minnesota Senior Federation continues to organize throughout Minnesota and throughout other key states unfairly affected by Medicare disparities. Numerous other attorneys general have joined Minnesota to fight for Medicare equity by either filing individual law suits or filing Amici Curiae (Friend of the Court) briefs.”

“Medicare, the nation’s largest health insurance program serving approximately 39 million elderly and disabled Americans, was enacted in 1965 as a uniform, nondiscriminatory, nationwide program based on equality in funding and equality in the provision of a standardized package of health benefits to beneficiaries regardless of where they reside. In 1972, Congress enacted, and the Department of Health and Human Services implemented, amendments to the Social Security Act designed to provide Medicare to beneficiaries through managed care organizations, using a reimbursement formula. That formula has allegedly transformed from a nondiscriminatory, uniform na-

tional program into one in which the availability and cost varies county by county, despite that all beneficiaries make equal contributions into Medicare.”

“Minnesota’s lawsuit claimed that the current Medicare program has created an unfair, two-tier health care system for older Americans based simply on where they live, and that Congress and the Health Care Finance Administration allow for over a 200-percent variance in Medicare reimbursement to counties across the country, allegedly making the practice biased and discriminatory.”

“In addition to the Minnesota Senior Federation and the Minnesota attorney general, plaintiffs included 72-year-old Mary Sarno, who resides in Florida. Because her daughter lives in Minnesota, Ms. Sarno wants to move to Minnesota, but she cannot because the Medicare Part C health coverage in Minnesota is insufficient to meet her healthcare expenses and needs as compared to her current Medicare managed plan in Florida where she pays no annual premium, no co-payment for visiting her doctor, and pays nothing for prescription drug coverage or for emergency medical services. By contrast, if enrolled in a Medicare managed care plan in Dakota County, MN, she would pay a significant annual premium of over \$1,000, incur a \$30 co-payment for emergency services and a \$30 co-payment for urgent care. She would also have to pay for all of her outpatient prescription drug expenses.”

Rural Issues Getting More Serious Face Time

From “Senate Subcommittee Addresses Rural Hospital Care,” *Medicine & Health*, 7/14/00: “

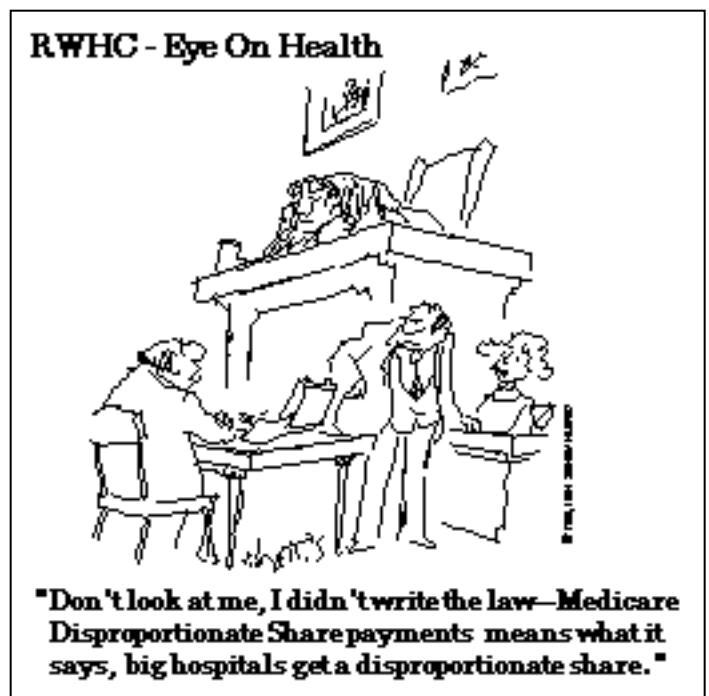
“Key Rural Health Service Threatened--The importance of rural hospitals, their problems, and what part Medicare plays in them were the focus of a Senate subcommittee hearing on July 11th. Mary Wakefield, Director of George Mason University’s Center for Health Policy, Research, and Ethics, called rural hospitals ‘a lynchpin for the development of local and regional health care services.’ ”

“Wakefield explained that there is ‘little service redundancy in rural areas, especially in small towns,’ and noted that ‘a rural town’s only hospital likely has the only outpatient surgery unit, the only radiology unit, and the only clinical laboratory. Its outpatient clinic may be the only primary care practice in town, and it may have the only ambulance service and the only home health agency.’ Added Jimmy Blessit, Administrator of South Sunflower County Hospital in

Indianola, Mississippi: ‘In rural communities all across this country, the local hospital...is often one of the largest employees with the most highly trained and highest paid employees in the community.’ Health care provides 10 to 15 percent of jobs in many rural counties, and indirectly accounts for 15 to 20 percent of all jobs there, Wakefield told the Agriculture, Rural Development, and Related Agencies Subcommittee of the Senate Appropriations Committee.”

“Witnesses agreed that rural hospitals were in precarious shape financially. Tom Scully, President of the Federation of American Hospital Systems, said that all hospitals had been hit hard by payment reductions stemming from the Balanced Budget Act of 1997, and that rural hospitals had been hit the hardest. Scully explained that rural hospitals have a relatively higher percentage of Medicare patients--63 percent on average--as well as a higher percentage of patients using Medicaid. Wakefield cited figures from 1998, the year BBA began to have an effect on hospital revenues. In that year, she said, the overall Medicare margin for urban hospitals was 15.8 percent, a year-over-year decrease of 2.3 percent, while the overall margin for rural hospitals was down to 5.2 percent, after a 4.3 percent decline in just one year.”

“Urban Bias Of DSH Payments--The issue often cited by witnesses as most crucial was the bias toward urban areas of Medicare’s Disproportionate Share (DSH) payments, which are designed to compensate hospitals that treat a disproportionate share of low-income patients. In 1998, urban hospitals received 95 percent of \$4.5 billion in total DSH payments. Only a



fifth of rural hospitals received those payments, compared to almost half of urban hospitals. In general, Scully noted, rural hospitals had to have 40 percent of their patients as indigent patients to receive DSH payments, versus only 15 percent for urban hospitals. Scully and other witnesses urged that the DSH formula be made more fair to rural hospitals. Scully said this should not be done at the expense of existing payments to urban hospitals already hurting from the BBA. Wakefield pointed out that the Medicare Payment Advisory Commission, of which she is a member, has repeatedly advocated making DSH payments more fair to rural hospitals.”

“Witnesses Examine Wage Index Calculations--

Another area which participants focused on was Medicare's hospital wage index, which is meant to adjust payments to reflect local labor costs. The wage indices for rural areas, which HCFA generally considers low-cost labor markets, tend to decrease payments to hospitals, while the indices for urban areas, generally considered high-cost markets by HCFA, tend to increase payments. The index affects a percentage of potential payments determined by a HCFA-calculated national average of hospital labor costs as a percentage of total hospital costs; the bigger HCFA calculates that national average percentage to be, the greater the portion of potential payment affected by the wage indices, and the more rural payments are reduced and urban payments are increased.”

“HCFA has calculated its national average percentage for labor costs as 71 percent of total costs, which Blessit claimed is substantially higher than the actual percentage for his hospital in rural Mississippi and for most rural hospitals. In his testimony to the subcommittee, Sen. Charles Grassley (R-IA) described S.2828, his attempt to address this problem. Under the bill, the wage index would be applied only to a percentage of potential payment determined by the actual percentage of labor costs against total costs for the particular hospital involved.”

“Witnesses expressed other concerns about how the wage index for an area is calculated. For instance, Wakefield said that ‘while the index should rightly reflect labor costs that are beyond a hospital's control, it should not reflect a rich occupational mix that results from a hospital's desire to enhance its staffing. But in fact, the current index is calculated on averages in actual payrolls rather than the relative differences in wage scales.’ She also noted that all rural areas in a given state are considered to be in the same labor market for the purposes of calculating the wage index, no matter how much actual wages vary, while one rural area bisected by a state line is considered two labor markets. Wakefield cited new urgency in addressing

wage index issues because the flawed index calculations will be used in the new prospective payment systems mandated by the BBA for outpatient care, skilled nursing, home health, and ambulance services. Rural hospitals will be particularly affected by this, she said, because of their role in providing a wide range of health services for their communities: 72 percent of all rural hospitals will come under at least two of the new PPS payment policies, and 21 percent will be subject to at least three.”

“Low Volume Adjustment Proposed--Because of fixed overhead costs and low patient volume, Wakefield said, rural hospitals have difficulty under Medicare's policy of paying all providers the same base price for the same procedure: ‘An X-ray machine and a minimal staff are required for a radiology lab, whether it takes five X-rays a day or 50.’ Wakefield said that ‘it is time for Congress to consider including a low volume adjustment for small, isolated rural providers for all of the prospective payment systems: the new systems as well as inpatient PPS.’ She said this could be done cheaply because small rural hospitals receive only a tiny portion of Medicare payments. In 1996, according to the Prospective Payment Advisory Commission, rural hospitals under 50 beds received only two percent of Medicare inpatient PPS operating payments, and those having between 50 and 99 beds got only four percent.”

The Perfect Storm--Part II

From an editorial, “A Decline in Health Insurance,” *Washington Post*, 7/24/00:

“The Nation's health insurance systems, both public and private, continue to deteriorate. A new report (by the Urban Institute's health policy center) on the period 1994-98 underscores the power and ominous implications of the trend. These were prosperous years in which millions of people moved up the income ladder, from lower- to middle-income status as well as from middle to high. In theory, the economic progress should have produced a decline in the number of people without insurance, because the higher the income, the greater the likelihood a person will be insured.”

“But in fact, the number of people, and not just poor people, without insurance continued to increase. The study was confined to the non-elderly, because the elderly all have Medicare. The percentage of the non-elderly lacking insurance rose, from 17.3 percent in 1994 to 18.4 percent in 1998. That's close to one person in five. In absolute terms, 4.2 million more people

were uninsured. The figure would have been much higher had the economy not been thriving. Prosperity has masked the increasing weakness of the health insurance arrangements on which the society depends.”

“The study was led by John Holahan, director of the Urban Institute’s health policy center. The country faces a problem that prosperity perhaps has done less to alleviate than to obscure. This understated report has little chance of being much heard in the clamor of the election year. But the politicians should heed it; so might the budget estimators. The health insurance system is beginning to fail even some of the better off, much less the needy. It needs to be strengthened; the strengthening, whatever form it takes, almost surely will require a major government subsidy. That’s on top of the funding that will be required to shore up Social Security and Medicare, pay for national defense, etc. The estimators say there’s a budget surplus, and the politicians are cheerfully dispensing it. The surplus gets a lot smaller if you think, as we do, that the government has a part to play in reducing the alarming and steadily increasing number of uninsured.”

System Failure Hits Small Employers Hardest

From “Focus On Prohibitive Health-Care Costs – Government Help May Be On The Way For Small-Business Owners Who Cannot Provide Their Employees With Adequate Benefits” by Daniel Kadlec in *Time*, July 17, 2000:

“How can you tell a cashier at Sears from a cashier at Pop’s Bagels? Just look at the teeth. Odds are, the Pop’s employee has no dental plan. Odds are, in fact, the Pop’s cashier has no health plan at all and is either skimping on basic medical needs or going broke trying to stay fit. Sound familiar? Indeed, some 44 million Americans are without health insurance, and 60% of them work in businesses employing fewer than 500 people or are family members of those who do. Most are at shops employing fewer than 25, where the high cost of insurance often forces owners to choose between health benefits and decent pay raises.”

“Small-business owners aren’t happy about this. They lose good workers every year to larger firms with better health plans, and this predicament has been their No. 1 concern in polls every year since 1986, according to the National Federation of Independent Business (NFIB). At long last, the issue is coming into focus in Congress and has surfaced in the presidential race.”

RWHC - Eye On Health



“Take your 30% premium hike and shove it.”

“Here’s the crux of the matter: while the cost of health care has risen about 10% a year recently, the cost to small businesses has gone up at about twice that rate. Many owners stop offering coverage or push costs onto employees, who then opt out. Basically, big companies with thousands of employees get better rates because the under-writers risks are spread out. One catastrophic illness is easily absorbed.”

“Big firms operate under federal Employee Retirement Income Security Act guidelines, which supersede varying and often baffling state insurance requirements. This lets national employers use one set of rules, simplifying the administration of health benefits. Moreover, ERISA guidelines in many cases are far less costly to implement than the state requirements, which may include coverage for such things as mental illness and alcoholism treatment, contraceptives, dentures and hair replacement.”

In Wisconsin, a Private Employer Health Care Coverage Board and the Department of Employee Trust Funds are charged with implementing a health care coverage program for small employers by January 1, 2001. All plans would be subject to the same laws that apply to group health benefit plans, mandated benefits. Participating employers are required to offer health care coverage under one or more plans to all permanent employees who have a normal work week of 30 or more hours, and pay for each employee at least 50%, but not more than 100%, of the lowest premium rate. The degree to which the promise of this initiative meets the substantial needs of Wisconsin’s small employers is an open question.

Stand Alone Hospitals Back In Fashion

From "Hospital CEOs More Optimistic," *Modern Healthcare*, 6/19/00:

"Every trend meets its end. That's what appears to have happened to the merger craze that gripped the hospital industry during the 1990s. Compared with six years ago, a new survey shows, a growing number of hospital chief executive officers expect their hospitals to remain independent."

"In 1994, fewer than one in five CEOs thought their hospitals would remain stand-alone; nearly half of CEOs feel that way today. The survey says the number of stand-alone hospitals has remained stable at about 60% over the past four years. Those are among the findings in the eighth edition of the Deloitte & Touche biennial report, 2000 U.S. Hospitals and the Future of Health Care Survey."

"The survey finds that CEOs' faith in remaining independent is so strong that a majority would restructure, eliminate clinical services and downsize facilities or staff before pursuing a merger if they thought their organization was in financial trouble. 'Evidently, the CEOs of independent organizations feel they have as good a chance to make it as a stand-alone entity as they do as part of a larger system,' the survey concludes."

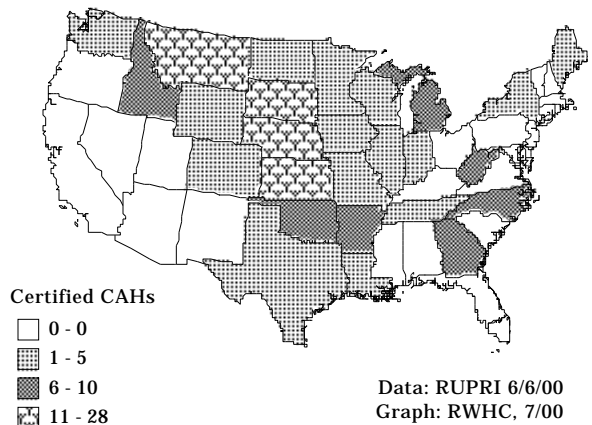
Feeding this optimism is that CEOs appear to be more confident about the financial health of their hospitals. The survey finds that only 25% of CEOs believe their hospital could fail in the next five years. A decade ago, 43% of the CEOs surveyed had a fear of failure."

"Another reason stand-alone-hospital CEOs are choosing to remain independent is that they see few benefits in merging. The survey finds that 'many of their merged colleagues are not reporting significant cost savings benefits from their decision to join a larger organization.' The newer CEOs have more confidence in their ability to deal with tough issues."

"As for managed care, the explosive growth CEOs expected never materialized. Today, 24% of hospitals report that HMOs account for 20% or more of their business. That's nothing when one considers CEO predictions of only two years ago. In 1998, 38% of CEOs believed that HMOs would account for more than 20% of their business by 2000. CEOs expect the slow growth of both HMOs and PPOs to continue."

"Also hitting the brakes is capitation as a payment mechanism. According to the survey, almost two out of three hospitals have no capitated contracts. Hospitals that do have capitated contracts are usually in suburban and urban markets. Hospital bosses are increasingly willing to cancel problematic HMO contracts. Nearly three out of 10 hospital chief executives say they have canceled an HMO contract."

Critical Access Hospitals Spread From Heartland



170 of approximately 900 potential CAHs are certified. All states are eligible and plan on participating except New Jersey and Rhode Island which have no rural hospitals. These smaller rural hospitals receive "reasonable cost" reimbursement to assure local access to Medicare beneficiaries in rural areas.

Competition Going Under The Microscope

Press Release, 7/20: "The US Agency for Healthcare Research and Quality (AHRQ) on Wednesday announced a 5-year, \$12.5-million initiative to examine the effects of market forces on healthcare."

"Investigators at Harvard Medical School, Boston, Massachusetts; University of California, San Francisco; and RAND, Santa Monica, California, and their collaborators will focus on the market's effects on quality of healthcare, access to care, and healthcare costs. The study is the largest, in size and duration, ever funded by the AHRQ, agency director Dr. John M. Eisenberg noted in a statement. It is also unique in that policymakers will be invited from time to time to discuss research findings and the implications for healthcare delivery. The projects proposed by each institution cover a broad range of issues, from managed care penetration in rural settings and health plan quality, to the impact of market competition on safety-net hospitals."

WISC Network for Health Policy Research

The Wisconsin Network for Health Policy Research helps to expand the boundaries of the University to encompass the entire state and its citizens. It believes in the connection between scholarship and public service that lies at the heart of The Wisconsin Ideal. The Network attempts to bridge the gap between researchers and public policymakers, providers, purchasers and consumers by bringing together people and data on health policy issues to improve and promote a broader understanding of the health of Wisconsin citizens.

Check out the new features and enhancements of the Wisconsin Network for Health Policy Research web site at www.medsch.wisc.edu/prevmed/network:

Electronic Newsletter--"Read or sign up for our electronic newsletter where you can find out about Wisconsin research findings and activities, upcoming Network events and news, data and links to data, health policy reports and activities."

Issue Briefs--"Download the Network's monthly issue briefs from our online publications. Issue briefs are produced to provide timely analysis of emerging health policy issues and current research findings."

Webcast Seminar Series--"The Wisconsin Network for Health Policy Research is pleased to now offer rebroadcasts of seminars from our Spring Seminar Series online. To listen to a seminar, simply click on the title. You will need to have a Real Player installed on your computer. If available, you may also view the PowerPoint slide show from the seminar."

Population Health Database--"The Network wants to improve electronic access to information on Wisconsin's health through the Population Health Database. This web resource is its first step, and includes Wisconsin county level population health data currently available on the web in an Excel format that can be easily accessed and analyzed."

Eye Examine Rules Out Pit Viper

A periodic *Eye On Health* feature are excerpts of letters from Dr. Linnea Smith from the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. The clinic operates with grass roots support from family and friends and many others. AMP is a non-profit, tax-exempt organization. Donations are wel-

comed c/o: Amazon Medical Project, Inc., 7600 Terrace Avenue, Suite 203, Middleton, Wisconsin 53562.

"Early June, 2000: Arrived home a couple of days ago, to find Mud Season in full swing. According to the marks left by the silt-laden water, this year's flood reached only to about the first three steps leading up to my front door, a good three or four feet below last year's near-record mark. This means that although I still took a canoe to the dining room for meals, I could walk to the clinic. It also means that everything in the world is a muddy mess. Edemita had swept and washed the floor of the house, and had the sheets washed, so it was fairly easy to move back in. The box seat for the latrine had already been moved down from its perch in the rafters (where it lives when the latrine is flooded), so all I had to do there was some cleaning of the box, and wading back 15 feet or so into the forest to retrieve the plank that lays on the ground in front of the box."

"Inside the house, I noticed a couple of 6 or 8-inch long sticks poking out of a slender vase that is mounted on one upright pole. They were about the diameter of a finger, were very glossy chocolate-brown, and had a whitish sort of tip. I wondered if they might be some kind of weird candy left by Sara, who had spent a couple of weeks in the house after I left. When I picked the vase off the wall and peered closely at the sticks, however, I realized: they are fungi. I have mushrooms growing inside my house."

"And the clinic has been busy. Sunday night, I was sound asleep when a tap came at the door a little before midnight. It was a very worried mother with a one-year-old child who had a fever and cough, had been given a syrup of some sort the day before and an injection earlier in the day, but seemed to be getting worse, or at least was not getting any better. Pneumonia is a major killer of small children here, so these cases must be taken seriously. The child had a fever, was breathing very rapidly, and had an inflamed ear drum. But her lungs sounded clear. I gave antibiotics, fever reducer, and instructions to return in the morning 'sin falta,' absolutely without fail."

"When the family had gone and I headed back to bed, I noticed what looked like the tail end of one of the leechy things we have around here, disappearing into one of the cracks between the horizontal boards that form the sides of my house. Then it occurred to me that the leechy things are flat, whereas this looked pretty round. I followed the opening between the boards and sure enough -- the entire opening was filled with the rest of a smallish snake, about as big around as my little finger and about a foot and a half long, with the usual arrowhead-shaped skull and narrow neck. I

shone my flashlight carefully (and from a respectful distance) at his eye to see if the pupil was round (benign) or vertical (pit viper). It was round. So I retired, home again as usual.”

“The next day’s first patient was one of the cooks at the lodge who wanted me to look at his athlete’s foot (and do something about it, of course).

Then the little girl of the night before did in fact show up as prescribed. She was a bit better, and her mother was a good deal happier. Another woman came in for a Pap smear -- she had had an abnormal Pap a couple of months ago, had taken the medicines we’d given her to get rid of inflammation, and was back for a follow-up Pap, to see if things have improved. Then there was a little guy with diarrhea, and his two healthy siblings for well-child visits (we weigh `em, measure `em, listen to their hearts and lungs, look in their mouths and urge better tooth brushing if they have the usual horrible and rotten teeth, scold the parents to boil their drinking water, and hand out worm medicine, vitamins, and toothbrush. Then I pulled a tooth for his 34-year-old daughter, and they went on their way. The next batch included a young woman for family plan-

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ning and her son for well-child care.”

“And so it goes. Sometimes, I tell you all about dramatic cases, and that is the stuff they make TV series of, and it is what people think of when they think of doctoring. But the truth is that much more of medicine has to do with an assortment of

illnesses that don't threaten lives but that do cause quite a bit of suffering. So, I'm going back to work. Till next time...”

The RWHC Patient Satisfaction Survey
As a rural hospital, it is important to have access to reliable data that you can use and trust when there are so many health care “report cards” readily available to consumers. The RWHC program provides easy to understand reports that will allow you to make sound QI decisions. Call 608-643-2343 or email office@rwhc.com.

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