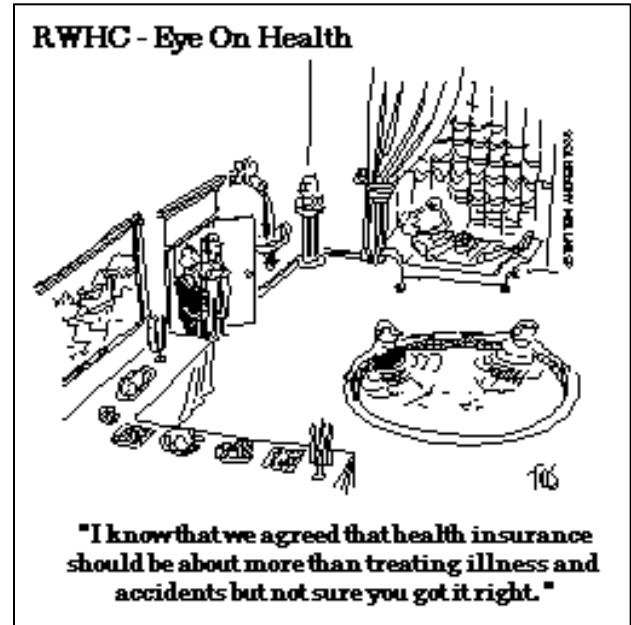


Purchasers Not Buying Behavioral Change

From a "Study Shows That Managed Care Plans Can Do More To Help Enrollees Change Unhealthy Behaviors--Purchasers See The Value in Health Behavior Change Programs But Are Reluctant To Buy Or Negotiate These Benefits For Workers," by Center for the Advancement of Health, <www.cfah.org>, 1/13/00:

"Although nearly half of the nation's premature deaths are linked with such things as unhealthy diet, inactivity or substance abuse, few managed care plans routinely use proven strategies to help their enrollees change these behaviors. A report from the Center for the Advancement of Health (CAH) shows that while most health plans offer some services to help members better manage chronic conditions or modify health risk behaviors, the majority of these efforts consist of handing out pamphlets--a practice known to be ineffectual in producing sustained change."

"The report is the first of its kind to assess the degree to which proven behavior change strategies are integrated into medical care. It is based on a 1999 survey

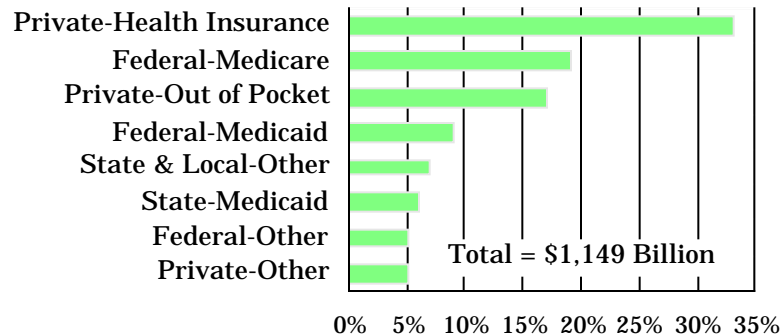


of HMO medical directors in five states and the District of Columbia, interviews with public and private health care purchasers, and an extensive review of the scientific literature on behavior change interventions in medical settings. The study focused on the attitudes and actions of both HMO medical directors and purchasers with regard to ensuring that evidence-based health behavior change services were offered to their members or beneficiaries. Specifically, both the HMO survey and purchaser interviews inquired about the provision of services to reduce risk (smoking, physical inactivity, unhealthy eating habits, and substance abuse) and to manage chronic diseases (asthma, back pain, heart disease, depression and diabetes)."

"The report finds that most HMO medical directors believe health behavior powerfully influences health outcomes. Behavioral health risks are tied to higher ambulatory care and hospitalization costs and account for as much as 70 percent of all medical care spending. However, health plans said they were reluctant to incorporate be-

National Health Expenditures in 1998

by Source of Funds



Source: Health Affairs, Jan-Feb, 2000  
Graph: RWHC 1/00

"We will not maximize the amount of health we achieve until a measure of health outcome becomes the purchasing standard for both the private and public sectors." David Kindig, MD, PhD, Purchasing Population Health.

havior change interventions into their systems of care, in part because the cost impact of doing so is unclear.”

“The survey also found that services to help patients better manage chronic diseases are treated and viewed differently than risk reduction services. While most health plans offer programs to help patients manage chronic disease as part of routine care, risk behavior change programs tend to be offered off-site and often result in out-of-pocket costs to patients. According to the report, behavior change efforts appear to be ‘fragmented within plans’ with one set of policies and standards in existence for disease management and another in place for behavioral risk reduction services.”

“Interviews with health care purchasers found that they also recognize the important role that behavior plays in health. Nevertheless, few purchasers negotiate with health plans for specific behavior change services. ‘We found that health care purchasers expect that when they buy a comprehensive health benefit from a managed care plan it will include effective strategies for controlling risky behaviors and managing chronic diseases,’ says CAH Executive Director Jessie Gruman, Ph.D. ‘Most employers or purchasers are unwilling to offer behavior intervention services directly to employees or negotiate for them separately with a health plan for fear of paying for these services twice,’ she adds.”

“Although there are many examples of evidence-based interventions that work, the Center’s analysis shows that incorporating these interventions into medical practice remains a ‘limited and piecemeal’ effort. Part of the problem, according to the findings, is that managed care decision-makers, health care purchasers, providers and consumers have had difficulty distinguishing effective behavior change approaches from unproven ones. Gruman says this needs to change, particularly since both health plans and health purchasers now recognize that the health of individuals is highly influenced by behavior. ‘Well designed and widely available behavior change services could--if fully implemented--make a significant contribution to improving health outcomes as well as reduce costs,’ says Gruman. Other highlights of the study:

- Access to health behavior change services is primarily tied to medical need or provider referral rather than on any systematic outreach to all those at risk within a health plan.
- Although they see the value in health behavior change services, most purchasers don’t feel they

have any leverage or ability to negotiate the type and quality of services plans offer their beneficiaries.

- The majority of purchasers report they do not have access to or make regular use of clinical and cost effectiveness data when making coverage decisions.”

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## Good Medicine Is Good Business

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From “Can a Provider-Owned HMO Model Really Work?” in *Integration Advisor* by Kristina Philipson and Janie Stifler for Towers Perrin, 9/99:

“By redefining the relationship between providers and consumers, provider sponsored health plans can change the dynamic between financing and delivery, and eliminate many of the tensions between the two. To achieve these goals, however, these health plans must effect change through active, honest dialogue between providers and consumers about their health care system. To really differentiate themselves in the market they need to:”

**“Listen more carefully to individual consumer and employer needs.** This may include sponsoring roundtable discussions between doctors, employers and employees to try to bridge the gap between care and its cost; talking about the ways individual behaviors influence the costs of care; talking about how the unwillingness of patients to participate in case or disease management programs will drive up their costs; dis-

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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cussing some of medicine's limitations, and looking for creative ways to get individuals involved in reducing health costs."

**"Developing products and services that integrate traditional and alternative medicine.** This includes examining the appeal of alternative medicine and looking at ways to weave it into traditional medical practices, and responding creatively but responsibly to the needs of the market. Health care cannot be entirely consumer driven, and providers must offer solutions that are clinically workable."

**"Examining strategic plans to determine whether the organization is being driven by consumer need or by the need to sustain the existing delivery system.** This can mean allowing the needs of the consumer-caregiver relationship--not the providers--to drive the configuration of the delivery system."

**"Challenging the traditional doctor-patient relationship, which often mirrors status differences in education and income.** Patients expect their physicians to know more than they do, but they do not want to be treated as if they do not know their own bodies and needs. Conducting focus groups with consumers can

identify behaviors that inhibit open communication between doctors and patients or that communicate a lack of concern for patient well-being."

**"Challenge the traditional hospital-doctor relationship that puts the needs of physicians above the needs of patients.** This is where many well meaning hospital customer service programs fail. While the hospital must treat physicians as important customers, the needs of patients should not be given second place. The key is to align the needs and incentives of doctors and patients to create a win-win service environment. this may mean finding physicians who model strong service behaviors and asking them to help lead the customer service program."

**"Challenge the traditional medical model that focuses on diagnosing and curing disease of the body, rather than the whole person.** Much of alternative medicine's appeal is its recognition that wellness encompasses both emotional and physical experience."

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## Listening To Insured Workers

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### Private Employer-Sponsored Health An Overview With New Estimates By State

	U.S.	WI.
<b>Percentage Offering Health</b>		
by number employees in firm <10	35%	38%
10-24	65%	70%
25-99	81%	82%
100-999	93%	89%
>999	97%	100%
total	53%	56%
<b>Percentage</b>		
2 or more plans	22%	12%
conventional indemnity	28%	31%
any managed care plan	79%	72%
exclusive provider	33%	21%
preferred provider	56%	53%
<b>Total Annual</b>		
single	\$1,997	\$2,112
family	\$4,953	\$5,116
<b>Percentage Employee</b>		
single	17%	16%
family	29%	23%

Source: *Health Affairs*, Jan-Feb, 2000  
Graph: RWHC 1/00

From "Listening To Workers, Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance" by Lisa Duchon, 1/00:

"Employer-sponsored and -financed health insurance provides the foundation for coverage of working-age Americans and their dependents. Today, 155 million Americans under age 65—two of three (65%) in this age group—have job-based health coverage. Yet despite tight labor markets, this foundation fails to cover a sizable portion of the workforce: 44 million were uninsured in 1998, the vast majority of whom were working or were dependents of workers."

"The steady rise in the number of uninsured Americans, despite strong economic growth, has revived national interest in health insurance system reforms that could improve coverage for working men and women. Key to the development of reforms that match the needs and preferences of workers is a better understanding of who is and is not well-served by the current employer-based system, how people perceive the performance of this system, and how they feel about various proposals to expand coverage for workers and their families."

“To inform national debate on the current state of employer-based coverage and public confidence in its future, The Commonwealth Fund commissioned Princeton Survey Research Associates, to conduct the 1999 National Survey of Workers’ Health Insurance. The study included telephone interviews with a national sample of 5,002 adults ages 18 to 64 conducted from January through May 1999. An array of questions explored views of employers as health plan sponsors and preferences for the future and probed personal experiences with coverage and health care. The survey findings provide an up-to-date picture of working-age adults’ health insurance circumstances on the eve of the 21<sup>st</sup> century.”

“Looking forward, the survey finds half of all adults in favor of employers continuing to serve as the main source of coverage for the working population. Employers emerged as the leading choice for the future even among the uninsured. Survey respondents’ personal experiences reveal, however, that challenges lie ahead if this foundation is to work for all working families. Sharp disparities in the availability of job-based health coverage are reflected in the one-third of middle- and low-income adults who are uninsured, even when working full-time. Millions more may be at risk for dropping job-based coverage because of inability to pay their share of insurance premiums.”

“Moreover, insurance is often insecure and of uneven quality, and frequent changes in health plans are a shared concern nationwide.”

“Other important survey findings include:

- Adults strongly prefer group insurance—whether employer or public—over purchasing insurance on their own. Two-thirds (67%) want either employers or the government to sponsor insurance plans, while only one of four (23%) would prefer workers purchasing coverage individually.
- Excluding the self-employed, one-fifth of employees, or 20 million workers, have not been offered a plan or are ineligible for coverage through their job.
- Even when working for larger employers, low-wage employees often remain outside employer coverage. One-third of workers earning less than \$20,000 who are employed by larger, private firms reported that no plan was available to them.
- The costs of participating can be prohibitive. One of seven workers declined coverage, usually because of the cost. Another 16 percent were finding it difficult to pay their share of premiums for employer cov-

erage. In all, nearly one-third of low-wage workers are stretching their budgets to pay their share.

- Forty-two percent of full-time workers with incomes below \$20,000 were uninsured, as were one-third of all full-time Hispanic workers.
- Nearly seven of 10 uninsured adults went without needed health care due to costs or were unable to pay their medical bills.
- Insurance quality varies widely. Less than one-third of those with employer plans rated their coverage as ‘excellent,’ with negative ratings reaching 30 percent among low-income adults.
- Coverage is unstable. Less than half of all adults have been in their current health plan for at least three years.”

Full report at : <<http://CommonwealthFund.org/>>

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## Into The Looking Glass--An Investor’s View

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From “Dow 10,000--Health Care Services 0” by Jay Harris in *Industry Insights*, a newsletter by Cain Brothers, Investment Bankers, 12/6/99:

“Most health care stocks have looked like a Mark McGuire home run, up, down, and then gone. From 1996 to 1999, a health care services stock index, as a percent of the S&P 500 Index, went from a high of 208% to a recent low of 108%, nearly a 50% drop. Certain sub-sectors, such as long-term care and physician practice management, have virtually disappeared.”

“How can a large *and growing sector*, which has benefited from a generic reduction in interest rates, perform so poorly? Clearly the answer lies in corporate profits (Publicly traded firms from 1996-1999 saw declines in total profits--HMO sector down 5%, Physician Practice sector down 58%, Hospital sector down 53%.) When profits decrease this much, as other sectors improve, investors bail out in droves. Is there any hope they will return?”

“Despite recent improvement, HMOs have generally experienced a double whammy: the end of an unusually long and positive ‘insurance cycle’ (almost ten years) and significant political and legal pressure. While the recent litigation cloud is likely to create short-term uncertainty and perhaps some cash payouts, this issue is unlikely to persist as settlements are

reached and/or legislative limits are enacted. Expect bluer skies ahead in the next 12 months.”

“Physician practice management appears to be a public company notion that has come and gone. As a professional services industry that needs relatively few funds for capital investment (other than information technology) and R&D, perhaps it should never have been taken public? Beware of businesses that don’t really need outside investors. Chalk PPMs up to a mid 90’s phenomenon.”

“The hospital sector (and its less glamorous cousin, long-term care) have suffered from reduced Medicare reimbursement, subcontracting from private insurers, and some large fraud and abuse settlements. Presumably fraud and abuse, like HMO litigation, is a short term problem. The key remaining question is: Can the hospital sector recover from Medicare and managed care pricing pressures? Probably not soon. Medicare budget pressures and cut backs are likely to be unrelenting. There are no easy fixes as there were when DRGs were enacted and Medicare has caught on to the niche reimbursement games (ventilator patients, home health, and skilled nursing facilities, to name a few), eliminating some mitigating opportunities. So, expect the hospital industry to take at least several years to sort things out and perhaps five years to return to higher profit levels. Call it a long-term hold.”

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## WI Credit Assessment Program Renewed

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The Wisconsin Health & Educational Facilities Authority (WHEFA), at a January meeting of the Members, renewed its funding support to continue the popular Standard & Poor’s (S&P) Credit Assessment Program. The following program description is taken from *WHEFA Capital Comments*, 12/99:

“The program helps eligible borrowers identify their financial strengths and weaknesses and to confirm a debt rating category for their organization. By knowing its rating before a financing is imminent, a borrower can develop a more appropriate borrowing

### Wisconsin Health & Educational Facilities Authority Annual Conference, March 30<sup>th</sup>, Waukesha

Call 262-792-0466 for more info on these sessions:

Assessing the Benefits of Public vs. Direct Debt Placement

Understanding the Tax-Exempt Financing Process

Trends in Long Term Care

What Investors are Looking for in Healthcare Bonds

Useful Technique Like Off Balance Sheet Financing

Enhancing Your Investment Guidelines & Returns

Economic Trends & Their Impact on the Health Sector

What’s New at WHEFA with Financing Assistance?

structure. The borrower can also work on its indicated strengths and weaknesses to maintain or improve its rating prior to its next financing.”

“Institutions interested in receiving a credit assessment prepare a package of financial, demographic and operational data detailing their recent historical operations. If specific near-term capitals needs

and borrowing requirements have been identified, they will also be detailed. S&P will review the information provided and will engage the facility in a follow-up telephone interview.”

“S&P issues a written report which (1) identifies the current most likely rating category, (2) highlights strength and weaknesses, (3) lists actions or improvements which could result in a more favorable rating and (4) if a borrowing is imminent, a debt capacity analysis.”

*If you are interested in obtaining this service, call WHEFA at 262-792-0466.*

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## False & Real Threats To Social Security

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From the “January 2000 Feature” in *AARP Bulletin*:

“After months of partisan rhetoric in which leaders of each party accused the other of ‘raiding’ Social Security, many Americans were left with the feeling that their Social Security taxes have been stolen over the years. AARP Bulletin Editor Elliot Carlson (**B**) last month asked Brookings Institution economist Robert D. Reischauer to discuss the raiding issue and the impact of congressional action on the Social Security trust fund. Reischauer (**R**) served as director of the Congressional Budget Office (1989-95) and recently was named president of the Urban Institute, a leading Washington research group.”

**B:** “GOP House Speaker Dennis Hastert said on ‘Face the Nation’ in September that House Republicans were not going to ‘dip into Social Security or raid the Social Security trust fund.’ Has the fund been raided--its money stolen?”

**R:** "The raiding notion is based on a misperception; the government has never raided the trust fund. The Social Security system lends its surpluses to the Treasury, which uses these resources to finance other government activity and thereby avoid going into public debt markets to borrow. All the money lent to the Treasury will be paid back with market-based interest when Social Security needs the funds to pay benefits."

**B:** "When these surpluses are loaned to the government to finance other programs, is the trust fund made weaker as a result?"

**R:** "Not in the least. Such lending does not affect current or future benefits, or current or future program revenues or the balances in the trust fund. And it therefore has no [negative] impact at all on the strength and security of the system. The Social Security system has to do something with its surpluses. By lending them to the Treasury, it is investing them in the most secure of assets-namely U.S. government bonds."

**B:** "We now have a standoff in Washington in which the leaders of both parties are pledging they won't touch the Social Security surplus to finance either increased spending or tax cuts. From an economic standpoint, is this a good development for Social Security?"

**R:** "Yes. Both parties have pledged to use surpluses in Social Security only to reduce the debt that the federal government has issued to the public. That does not constitute fundamental reform of Social Security. But it will strengthen our economy and our budget in ways that indirectly will benefit Social Security."

"For example, redeeming national debt will free up resources that the private sector can use for productive investments that will boost economic growth. If the economy is larger, the unavoidable burden of supporting benefits for ever larger numbers of retirees will be easier to bear."

**B:** "I wonder if some of that surplus couldn't be used for investment in such areas as education and medical research without doing damage to the picture you outlined?"

**R:** "In theory, the surplus could be as effectively invested in

activities that are thought to boost economic growth and raise living standards such as educational opportunities, improved health or infrastructure."

"The problem is that the mechanism for allocating resources to these activities is based on political, not economic, factors. The projects that are selected often aren't true investments. The money is distributed around the country because political interests are diffuse. Every area has to get its own bridge, highway, educational assistance, or health project. Some of these resources simply replace state and local government monies."

**B:** "We now have Republican leaders--and many Democrats joining them--calling for a 'lockbox' mechanism that would seal off the Social Security surplus from being used to pay for other government activities. Can this be done?"

**R:** "There's no effective procedural way to create a lockbox. Nevertheless, we have recently adopted a psychological lockbox that may be more effective than any new formal budget rules. For at least the three decades before 1999, we regarded the measure of fiscal rectitude to be: Balance in the overall budget. Counted as part of the overall budget was everything from Social Security to defense on the spending side and from payroll taxes to gas and income taxes on the revenue side."

"About a year ago we changed our measure of fiscal rectitude to be: Balance in the budget, not counting the surpluses in the Social Security program."

"This means there is a political imperative to wall off the surpluses that develop in Social Security and use them for debt reduction."

**B:** "If enacted, would the 'lockbox' make the Social Security trust fund any safer than it is now?"

**R:** "No. It would have no impact on the security of the trust fund. The trust fund is as secure as possible right now."

**B:** "What, then, would be the net effect of adopting a 'lockbox?'"

**R:** "If an effective lockbox could be devised, it would ensure that the revenues in the

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non-Social Security portion of the budget were always sufficient to pay for all of the activities in the non-Social Security portion of the budget.”

**B:** “If they fail to adopt a lockbox, will this negatively affect the trust fund?”

**R:** “No, it will not.”

**B:** “Some critics argue that the interest income the trust fund gets from the government is too small, because the surpluses are invested in nonmarketable bonds. Could the fund do better investing in marketable bonds that pay higher rates?”

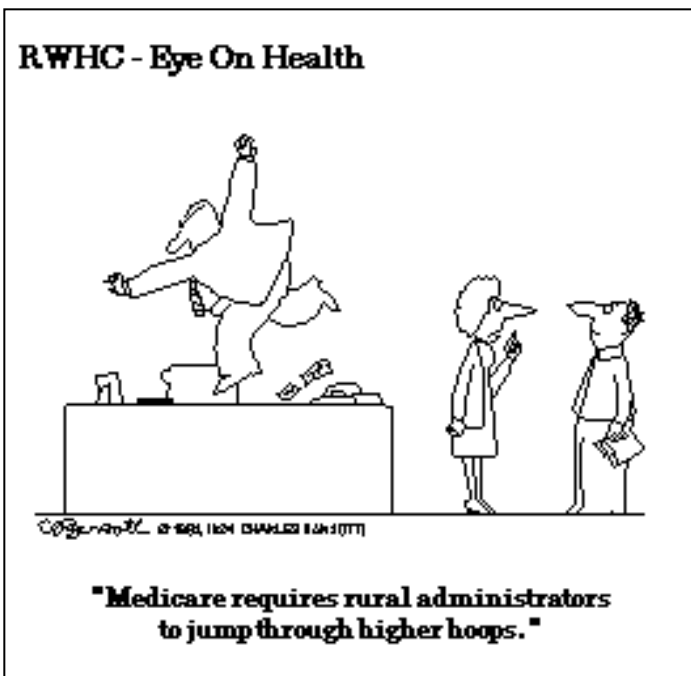
**R:** “By law, the surpluses generated by Social Security must be invested in government securities, or government-backed securities.”

“The interest paid on the particular bonds that Social Security is given in return for its surpluses is an average of the interest rates on outstanding government securities with maturities of four or more years.”

“In other words, the government is paying very close attention to the prevailing rate for government securities available in the market.”

“Could Social Security over the long run do better by diversifying its portfolio into equities and corporate bonds? Yes. But the price of doing that would be an acceptance of greater risk.”

**B:** “If Social Security’s problems can’t be traced to raiding of the trust fund, what is the cause?”



**R:** “The problem is largely one of demographics and past decisions to pay previous generations of retirees adequate benefits even though they made very modest contributions to the system. The baby-boom generation will soon be retiring and the smaller baby-bust generation that followed won’t contribute sufficient amounts to support the benefits promised to the baby boomers unless payroll tax rates are raised significantly.”

“In addition, we are living longer. Tomorrow’s retirees will receive benefits for more years than today’s or yesterday’s retirees. Unless we raise the age of eligibility along with the increases in longevity, taxes will have to be raised or benefit levels cut a bit.”

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## Too Few Hospital Beds?

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A traditional frustration (and source of some humor) for many rural advocates is how rural issues are frequently missed or not reported during the course of general news reporting. The following article, edited only for length, is a good example--“A Bed Dispute” by Mark Taylor in *Modern Healthcare*, 1/3/00. (The larger rural policy issue embedded but not identified in this dispute is noted in italics after the excerpt.)

“How much is a bed worth? To two central Kentucky hospitals suing the federal Department of Health & Human Services, the answer is \$7.5 million.”

“Richmond’s Pattie A. Clay Hospital, an 80-bed facility managed by Jewish Hospital HealthCare Services of Louisville, Ky., and Winchester’s Clark Regional Medical Center, a 75-bed community not-for-profit hospital, filed suit in U.S. District Court in Lexington, Ky., seeking return of \$7.5 million they were required to pay to the government because of a disagreement about the definition of the word ‘bed.’ ”

“The hospitals allege that a change in how the federal government counts inpatient hospital beds reduced their total beds on Medicare cost reports, bumping them down into a lower reimbursement category that cost them millions.”

“That formula change dropped them below the 100 bed threshold that made them eligible for higher payments under the federal disproportionate-share hospital program, which compensates hospitals for treating unusually high numbers of low-income patients.”

“Those rules generally require that 15% of patients at qualifying hospitals with 100 or more beds must be low

income. At hospitals with fewer than 100 beds, 40% of patients must be low-income.”

“At issue is whether the federal government should include swing beds and observational beds in its disproportionate-share bed count, or tally only acute-care beds as recognized by Medicare.”

*In an age where we are encouraging fewer beds, why a federal incentive to have more beds? Why do hospitals with fewer than a 100 beds have to meet a threshold 2.5 times that of larger hospitals. Science or politics?*

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## Rural Clot Busters

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From “Treating Acute Stroke Patients With Intravenous Pa.,” by David Z. Wang, D.O. et al in *Stroke* (Journal of the American Heart Association), 1/00:

“By getting support from regional medical centers, smaller hospitals located in rural areas can effectively treat stroke patients with clot-busting medication, according to a study in this month’s *Stroke: Journal of the American Heart Association*. Researchers found that clot-busting medication called TPA (tissue plasminogen activator) was given safely and resulted in good outcomes for patients at community and rural hospitals that created and followed a stroke care protocol. According to researchers, lack of a stroke treatment protocol is one major reason the clot-buster is not given more often in small hospitals.”

“TPA is the only FDA-approved treatment for acute stroke. TPA must be given within three hours of stroke onset to be effective. TPA is used in patients with ischemic stroke, which is caused by a clot blocking blood flow to the brain. About 80 percent of all strokes are caused by blood clots. ‘This study demonstrated that TPA can be safely given to acute stroke patients in rural and community hospitals with or without an on-site neurologist,’ says the study’s lead author, David Z. Wang, D.O., director of the OSF (Sisters of the Third Order of St. Francis) Stroke Network in Peoria, Ill. ‘By following the protocol, small hospitals can deliver good care to stroke patients.’ ”

“Because of the lack of available neurologists in a particular area, rural hospitals sometimes have to rely on phone contact or other means by which to consult with an off-site neurologist. The neurologist can give the authorization for TPA to be given by emergency physicians or, in some cases, primary care physicians.”

## Two Key April Dates In Wisconsin Rural Health

**April 15<sup>th</sup>** is the annual deadline for The Hermes Monato, Jr. Essay Prize--\$1,000 awarded for the best rural health essay or paper. Open to students of the University of Wisconsin-Madison, who are associated with the Center for Health Sciences. All information needed can be found at <[www.rwhc.com](http://www.rwhc.com)>.

**April 27th-28th** The Wisconsin Rural Health Association's Annual Conference is at the 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](mailto:bduerst@facstaff.wisc.edu)>.

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## Wheelchair--The Sequel

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From “Of Wheelchairs and Managed Care” by Andrew Batavia, *Health Affairs*, November/December, 1999:

### *A Recap from last month's Eye on Health*

“After twenty-five years of living with high-level quadriplegia, I was familiar with the routine. Every five or six years my wheelchair-repair person would tell me that my chin-controlled motorized wheelchair was getting old and could be expected to break down with increasing frequency in the coming year. I would then ask my primary care physician to write a prescription for a new motorized wheelchair using the precise specifications I provided, send the prescription to my insurance company, and prepare for battle. I never looked forward to the kabuki dance that would follow, but I was able to endure it, content in the knowledge that I would ultimately prevail and obtain the wheelchair I needed to maintain my independence and employment.”

“However, last year the routine changed. I had the same conversation with my wheelchair-repair person. I presented the same list of specifications to my primary care physician, and I was prepared to take my combat position in the epic confrontation with my preferred provider organization (PPO), Blue Cross and Blue Shield (BCBS) of Florida. However, this time



I found that the battle lines and alliances had changed. For the first time in my life as a person with a disability, my primary care physician refused to write the prescription. For the first time I was not certain whether I would be able to obtain the wheelchair I needed.”

### *The Rest of the Story*

“Why was my primary care physician effectively abandoning me in my effort to get a new wheelchair? Maybe he really believed that writing this prescription without having better knowledge of wheelchairs constituted fraud. More likely, he was afraid to anger the PPO by authorizing an expensive wheelchair that the PPO would have to pay for. Perhaps he was concerned that there would be negative repercussions such as being removed from the provider network, which could affect his livelihood. Whatever the actual reason, I was incredulous that my own primary care physician would not write me a prescription for my wheelchair.”

“Having analyzed my situation, I then called the BCBS representative to learn the company’s position. She indicated that the PPO might be willing to pay for a new wheelchair but that it could not do anything until it received a prescription from my physician. By this time I was beginning to develop conspiracy theories: My physician is unwilling to write a prescription unless my PPO is willing to pay to repair the chair, and my PPO is unwilling to pay for a new chair unless my physician is willing to write a prescription for it. A classic Catch-22.”

“I was at a temporary impasse. This was not progressing at all according to my plan. I was used to fighting but not to losing. Yet, as an American familiar with the workings of our arcane health care financing system, I had not yet begun to fight. I figured there must be some physician in the network who would be willing to write a prescription for a wheelchair that I obviously needed. This time, I sought out a physiatrist—that is, a doctor of physical medicine and rehabilitation.”

“I duly paid the co-payment to speak with a physiatrist in the PPO network. Much to my chagrin, he informed me that he does not have any quadriplegic patients and that those of his patients who use wheelchairs either use manual (non-motorized) or relatively unsophisticated motorized chairs. Therefore, he did not feel qualified to write the prescription I required. However, after I badgered him persistently (a skill I first developed at Harvard Law School and have since perfected), he eventually agreed to write the prescription.”

“Some analysts might argue that wheelchairs should not even be financed under the health care system, claiming that insurance is intended to protect against risks and that wheelchair costs are certain and predictable. However, wheelchairs have been financed through health care traditionally, and if we are going to change this, we must first develop an alternative source of funding that is reliable and adequate. In the meantime, the current system is inefficient and inequitable, from the perspective of both the consumer and the provider. My experience should demonstrate that change is needed.”

### ***La Doctura, The Journal of an American Doctor Practicing Medicine on the Amazon River***

La Doctura by Linnea Smith, M.D., is now available in paperback. Linnea, who went to South America from her medical practice in Sauk City and Prairie du Sac, periodically provides *Eye On Health* excerpts from her letters home.

More info is available about the Amazon Medical Project, Inc at <[www.amazonmedical.org](http://www.amazonmedical.org)>.

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### **Bringing Heart & Soul Back Into Medicine**

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From the jacket of the newly published *Medicine In Search of Meaning, A Spiritual Journey for Physicians* by Bill Bazan. Bill is Vice President, Metro Milwaukee, for the Wisconsin Health and Hospital Association (WHA).

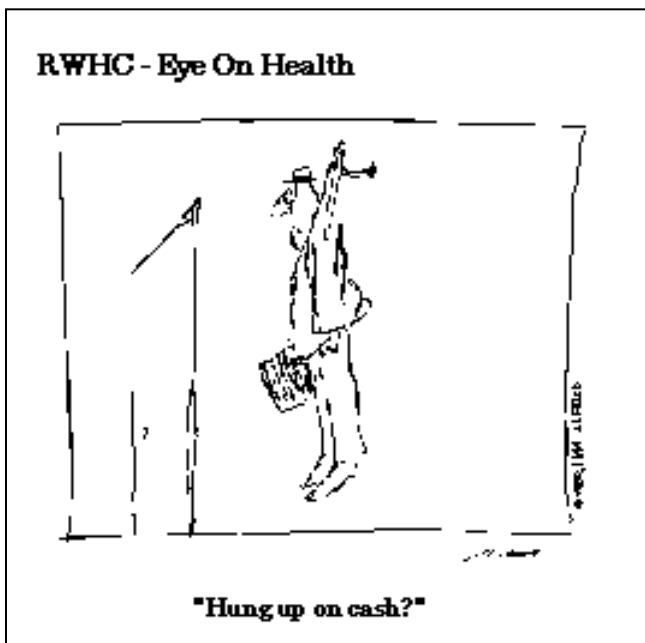
“What about a world of medicine that is changing so fast that the air is getting sucked out of the meaning that once gave solace and comfort to countless physicians? What about a medical culture that is being challenged to rethink and redefine its very purpose for existence? What about the autonomy issues that are being raised by physicians who feel the presence of faceless people--lawyers, insurance utilization review personnel, and health insurance executives--telling them how to practice medicine in their own examining rooms? What about the pressures coming from outside groups who want physicians to align with them in networks and not with their competitors? What about the fears that accompany physicians who are questioning whether or not they are still relevant for this new age of medicine and its delivery?”

“Finally, what about the physicians who believe medical school and medical training have left them hanging out to dry with little or no formation in the business side of medicine, much less in the human, spiritual side of medical practice; a medical training system that teaches diagnostic skills, vast sums of knowledge and technical development, but precious little on how to handle anger, frustration, bitterness and the demands of change?”

“ ‘*Medicine in Search of Meaning* is a wonderful, self-reflective book that will help physicians rekindle their passion for medicine and the patients they serve during these times of tumultuous change in the delivery of health care. Bill has brought the business of the heart and soul back into the business of medicine!’--Marvin Kolb, M.D., Medical Director, Kern County Hospital, Bakersfield, CA.”

“ ‘In his easy direct style, Bill Bazan offers physicians a way to reawaken the dream that brought all of us into the practice of medicine. He helps physicians bring a deeper sense of meaning and purpose into their world by developing their personal spirituality, thereby, accessing their inner dynamic forces of energy and power. Recipients of this energy are both the patients and the physicians.’--Len Scarpino, D.O., Director of the Family Residence Program, All Saints Health System, Racine, WI.”

*Copies can be purchased for \$14.95 plus \$4 S&H by contacting Dawn Bergen at WHA (608-268-1817) or by emailing Bill directly at <bbazan@mailbag.com>. Discounts available for multi-copy orders.*



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## A Guy's View Of E-Mail

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From “Comment--The Return of the Word” by Adam Gopnik in *The New Yorker*, 12/6/99:

“E-mail is the literary event of the late century. Ten years ago, even the most literate of us wrote maybe half a dozen letters a year, the rest of our lives took place on the telephone. There can not be ten people in America who have had their lives changed by virtual reality, or who have been hyper-linked into a new consciousness--but multitudes have found a nearly forgotten friendship suddenly made intimate again, because of E-mail, and are attentive once more to their sentences.”

“The reason this medium has blossomed is not that it gives you *more* intimacy; blessedly, it gives you *less*. The new appeal of E-mail is the old appeal of print. It isn't instant, it isn't immediate; it isn't in your face. Written language gives you a hat and a Groucho nose and glasses; it's you there, but not quite you. E-mail has succeeded brilliantly for the same reason that videophone failed miserably; what we actually want from our exchanges is the minimum human contact commensurate with the need to connect with other people. ‘Only connect.’ Yes, but *only* connect.”

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## Rural Leaders Again The Early Innovators

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From “Business Prognosticators Say It's Time For Tie To Die,” by Christopher Gimes, Dow Jones News Service, 12/24/99:

“Simon and colleagues at the Massachusetts Institute of Technology's Sloan School of Management recently compiled a list of business predictions for the 21<sup>st</sup> century. ‘The tie, I think, is finished,’ Johnson said. The new role models in business are Silicon Valley capitalists and Internet entrepreneurs, many of whom don't knot up, he noted.”

“ ‘I think a tie is going to be associated with not knowing what's going on,’ he said. So an open collar says ‘daring, risk taking CEO,’ while a tie grumbles ‘desk slave.’ ”