Rural Wisconsin
Health Cooperative

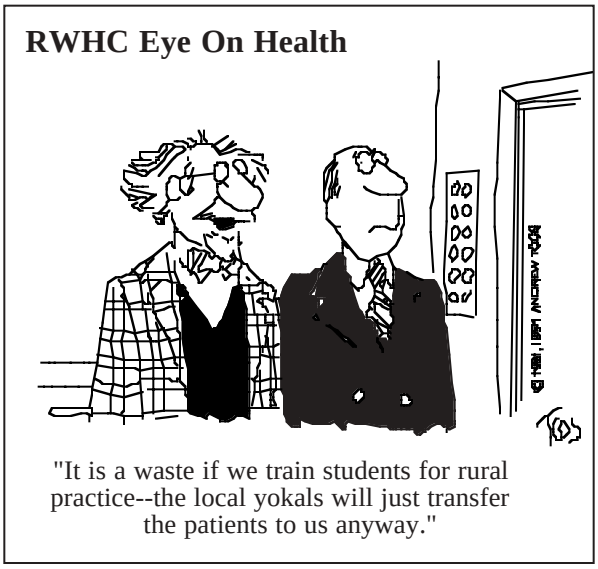
Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective - February 1st, 2002

Medical School Leadership Matters

From "The Rural Vs Urban Practice Decision" by H. Rabinowitz and N. Paynter in *MSJAMA*, 1/2/02:

"Americans living in rural areas have more health problems than their urban peers, yet there are fewer medical services available to them. A major part of the disparity between rural and urban health care is the longstanding shortage of physicians in rural areas. Although 20% of the US population lives in rural areas, only 9% of physicians practice there, and only 3% of recent medical school graduates plan to do so. Thus, it is important to understand why physicians choose to practice in rural vs. urban areas."



"It is a waste if we train students for rural practice--the local yokals will just transfer the patients to us anyway."

"There are a number of known predictors of choice of rural primary care, including rural background, freshman medical student plans for family practice, and receiving a National Health Service Corps scholarship. Women are slightly less likely to practice rural medicine than men, although this is not true for women who enter medical school committed to rural family practice. Spousal influence and economic issues also play a role in physicians' decisions about where to practice."

"During medical school, taking a rural clinical rotation is the strongest predictor of a later decision to practice in a rural setting. However, since most medical schools are located in urban areas, the vast majority of students have their clinical training there, while few have clinical experiences in rural areas. **Medical schools with special admissions programs and those with extensive rural curricula have been more successful in producing rural physicians, as have residency programs with rural training tracks,** although collectively these programs are too small to eliminate the US rural physician shortage."

"Physicians' decisions about where to practice are also related to their choice of specialty. Most urban physicians are not generalists, while a higher proportion of rural physicians are generalists. Family physicians are the only specialty group that distributes itself proportionally to the population in rural and urban areas. Thus, the size of the future rural physician workforce may be threatened by the trend of US medical students to increasingly train in non-generalist specialties and subspecialties, which persists despite evidence that provision of primary care is related to improved health outcomes."

"Physicians attracted to rural areas often cite their desire to raise a family in a rural setting as crucial to their decision. They may also value participation in outdoor activities, lower crime rates, less traffic, and living in a closely knit community. Although the average income of rural physicians is lower than that of their urban peers, this is due to the greater proportion of generalists in rural areas. Among family physicians, for example, net income in rural vs. urban areas is virtually identical. Because the cost of housing is substantially lower in most rural areas, this can result in a higher standard of living for many rural physicians."

"The scope of medical practice in rural areas is frequently more diverse than in urban areas. Rural family physicians, for example, often deliver more infants, have broader hospital privileges, and make

house calls. Rural physicians also retain more clinical independence in their practice."

"For medical students contemplating practice location, as with deciding on specialty choice, real world clinical experiences and role models facilitate decision-making and allow students to evaluate their own practice, lifestyle, and financial needs. To do so, students should consider obtaining clinical experience in both urban and rural settings."

First 2002 Shot Across Medicare Equity Bow

Wisconsin's Senator Russ Feingold has introduced legislation to reform the current Medicare reimbursement system by reducing regional inequities in Medicare spending and focusing on high-quality, low-cost Medicare services. It would:

Eliminate the higher payment index that is biased against Wisconsin: This provision requires improved fairness in payments to physicians and other health professionals under Medicare Part B by reforming the current formula used to determine Medicare payment rates.

Establish pilot programs to encourage high quality, low cost Medicare practices: This proposal would authorize a series of demonstration programs to encourage high-quality, low-cost health care to Medicare beneficiaries. These programs would reward states such as Wisconsin, whose providers deliver high quality at lower cost. It would also require that the states chosen to receive pilot programs create a plan to increase the number of providers who deliver high-quality, low-cost care to Medicare beneficiaries.

Establish a program to increase care in rural and urban areas: This provision would allow the Secretary of Health and Human Services to use existing Graduate Medical Education funds to create a program to encourage rural and urban health care providers to host clinical rotations, including incentives necessary to attract rural educators and clinical practitioners.

Promote equity in payments to nursing homes: Nursing homes employ a significantly different group of health care professionals from hospitals. However, they use the same hospital wage adjustment systems that discriminates against Wisconsin. The Center for Medicare and Medicaid Services (CMS) is already collecting nursing homes wage data, which could be used to promote accuracy in Medicare reimbursement for skilled nursing services. This provision would require CMS to use these data to modify skilled nursing facility payments by 10/1/02.

State Bipartisan Leadership Matters

Wisconsin's Private Employer Health Care Coverage Plan (PEHCCP) was created by State law in 1999 based on a model where state government acted as an "incubator" for a purchasing pool which would then be spun off to the private sector. The pool is designed to stabilize the small employer market place and to offer employees in small firms the same choices among insurers as is now available to many who work in larger companies. Necessary refining legislation has not been passed and adopted to prevent adverse risk selection against the pool as well as extending the pool's development funding. The pool was never intended to cure world hunger (the *EOH* Editor, as the PEHCCP Chair is not a neutral observer.) From "Hopping Mad, Small-Business Groups Decry Lack Of Health Insurance Legislation" by Julie Sneider in the Business Journal for Greater Milwaukee, 1/11/02:

"An extension seems unlikely due to the state's budget crisis, the insurance industry's opposition to some of the program's details and a lack of support from Gov. Scott McCallum. In a Jan. 8 meeting with Wisconsin business news editors, McCallum expressed doubt that the pool, modeled after a health insurance purchasing alliance in California, would be successful here as proposed."

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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" 'I wouldn't use California as an economic development model for Wisconsin,' McCallum said. He added that the proposed program 'would cause immense difficulties in the insurance industry.' "

"State Rep. Frank Urban, Rep. Gregg Underheim and other members of the Assembly Republican caucus have met in recent weeks to consider the causes of rising health care costs and possible legislative responses. 'The real problem is health care costs, and you can't solve that problem by fiddling with insurance regulations,' said Underheim, who chairs the Assembly Health Committee. 'Our ultimate goal is to come out with legislation that attacks the real problem.' "

"Walking Away Not An Option"

From "What Will It Take?" by Lewis Sandy, an internist and executive vice president of the Robert Wood Johnson Foundation in *The Washington Post*; 1/6/02:

"The day the stimulus package died in Washington, foundering on the question of how to extend health insurance to the jobless, I saw an elderly man in my clinic. Depressed, with symptoms of Parkinson's disease, he's had a partial response to medical therapy, but with side effects. With many frail seniors, improving outcomes and quality of life is a difficult balancing act in which therapies will have mixed effects. On the other hand, patients and families come to physicians to get help, to make things better. How would it be if we threw up our hands, said 'it's too complex' and left the patient to dwindle and suffer?"

"Health care accounts for nearly $1.5 trillion of the national economy, nearly 14 percent of the gross domestic product. In the aftermath of Sept. 11, health policy, and its inattention to public health, has become a national security issue. What will it take for our national leaders to squarely address health policy?"

"First, it will take an admission that there are no easy choices. **Conservatives will need to admit that marketplace reforms alone will not address the fundamental issues that make health care less than amenable to private-sector reforms.** These include the fact that most health spending occurs among the few who are extraordinarily sick or have complex chronic illness, and that people are very risk averse when it comes to health insurance, as evidenced by the lack of enthusiasm for medical savings accounts and what people buy for Medigap supplemental insurance."

"Liberals, on the other hand, will need to admit that expansions of health insurance coverage and mandating benefits cost huge amounts of money, both because health care is expensive and because of the unfortunate reality that insurance coverage often leads to increased utilization."

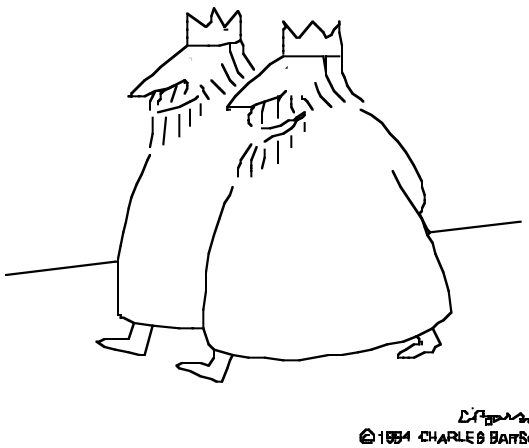
"Second, it will take a national dialogue on fairness and justice in health care. Why is it more important to provide resources to those who have lost coverage than to those who never had it? Why should tax revenues subsidize well-off seniors' prescription drugs and not provide preventive care to low-income workers?"

"Thus far, only Oregon has engaged in a public process to determine priorities within its Medicaid program—facing squarely the matter of who gets what and, perhaps more important, who doesn't—within the constraints of its Medicaid budget."

"The last time the nation clearly focused on fundamental health care issues was during the 1993-94 debate over the Clinton health plan. **Although many have analyzed why the Clinton plan failed, the most disappointing aspect of that process was the perpetuation, by all sides, of the 'free lunch' argument: that we could cover more Americans, increase quality and control costs without having to make tough choices."**

"Some are now predicting that health policy will return to the top of the political agenda next year. As a physician, I have a professional and moral obligation to provide the best possible care to my patients. Walking away from their problems is not an option. I wish our national leaders felt the same way."

RWHC Eye On Health



"The beauty of the 'free lunch' gambit is that as long as they believe we can do everything we have to do nothing."

The Health Care System: At Least Not Boring

From the Memorial Medical Center (Neillsville, WI) *Employee Newsletter* by Glen Grady, 12/01:

"2001 is finally in the books and a very eventful year it was. The unimaginable became a reality and 2001 will forever be much more than a just footnote in the history of human conflict. For many of us the year will also be remembered for the 'free fall' the local, national and world economy seemed to be in for much of the year. We consider it a free fall, but historians, economists, and mutual funds managers are quick to point out that the rapid expansion and globalization of the economy in the 1990's was not only unprecedented in a historical sense, but also unsustainable in an economic sense. What we may consider the beginning of 'bad times' was really only the continuation of the normal business cycle after a decade long period when the economy seemed to be stuck in high gear. So we are now just getting back to normal. But this new normalcy has and will continue to effect the way we, even in health care, do business."

"Health care workers are somewhat fortunate in that the need for their skills have and will not ebb any time in the foreseeable future. But the loss of jobs and rising unemployment rates in other sectors of the economy are starting to have a dramatic effect on the ability of the public to continue to pay for the services we provide. Companies that previously were biting the bullet and trying to absorb their employees health insurance premium increases are rethinking those policies. In a shrinking economy and with the globalization of production capabilities, they have been forced to. It is difficult to compete when your cost of production is being driven to levels much higher than those of your competition. Health insurance premiums, over which the employer has little control, are an obvious target as the employers struggles to stay competitive."

"Don't get me wrong. For the most part employers are very concerned with the health, safety and welfare of their workers and of the communities they are a part of. They want their employees to be able to continue to access the quality care they need at an affordable price. But there is a conflict between what they can afford and the price of the benefit. They know that price is in large part driven by something called 'cost shifting' from government programs. In a nutshell that means that Medicare and Medicaid have historically not increased what they pay for services at any where near the health care providers increased cost of doing business. The provider then, must increase the price to the other patients disproportionally to make up for those government patient shortfalls. Employers understand this problem very well and know that, for now, there is little they can do change that."

"But they also realize that the amount their employees use the service is a factor in premium increases. In the past, many insurance products gave first dollar coverage. They initially did this through health care indemnity insurance plans, and in later years tried to control their rapidly increasing cost with HMO and PPO products that although usually first dollar types of coverage's, somewhat limited the employees to what health care providers they could use."

"Even with these programs, the employee had little individual accountability for the cost of health care. So in an effort to give the employees at least some responsibility for that decision to access health care, most employers had plans redesigned to add a front end deductible for initially accessing health care in a plan year and then a small coinsurance for each physician contact after the deductible was met. These strategies were marginally effective in holding down premium increases for a few years."

"The reality of the aging of the workforce and the advances in treatment technologies made those savings quickly disappear. With the aging of the workforce, the small number of employees who needed very expensive specialty care (the cost of which has always made up the bulk of the insurance premium) started to grow. And the treatments that were available for this group of patients became much more numerous and more expensive. Even for the average employee with what once were considered normal effects of aging such as high blood pressure, arthritis, etc., there are new and expensive pharmacological options that can magically give him or her a better and longer life. Little effort on the employee's part, save remembering

to take pill, is required. This cost added to the premium cost at levels unforeseen by the employers—or for that matter, the insurance industry."

"This is where most employers find themselves today. They are very concerned with their employees ability to access needed health care, but they are seemingly unable to continue to support that benefit at the same levels as in the past."

"They are, however, not without options. Many larger employers are going to what are called 'cafeteria benefit plans.' These plans can involve several types of benefits but as they relate to health care it usually takes the following form. The employer puts a sum certain into an account for each employee and the employee chooses what level of health coverage he or she wants. The employer might offer two or three different employer sponsored health insurance programs with varying levels of coverage, or it might simply allow the employees to use the money to purchase their health care coverage on the open market. In either case, the employer pays the same amount towards any plan and the employee makes up the difference. The cost to the employer is predictable and the employee is far more individually accountable for the cost of his individual health care purchasing decisions."

"The changing economic fortunes could have more than just a ripple effect on our health care industry. At a minimum, as the unemployed and uninsured numbers rise, bad debts and charity cost will increase."

"Patients may become more discriminating in deciding when to access health care services. In the short run this could effect business volume. In the long term it may lead to conditions being left untreated that could become far more acute than needed."

"And government control solutions will again come to the forefront. The politicians hue and cry for everything from health care rate and capital purchasing regulation to national health insurance will continue to get louder."

How Do We Avoid The Rapidly Approaching Train Wreck Of American Health Care?

Answer: Check One

- ❒ **Government Micro-Management**
- ❒ **Predatory Competition**
- ❒ **Community Based Health Care**

"The legacy of the economic changes in 1990's and the turmoil of the first two years of this new century will continue to be with us in this new year and beyond. There are many and growing problems in all sectors of our society. But we go into the future with our heads high and with much hope. There are probably no utopian solutions to any of the challenges that we face from day to day. But we still live in a society and in a day and time when we are free to peruse those elusive solutions. Wouldn't it be a boring life if there were no problems left to solve?"

Value Purchasing—Work In Progress

From "Challenges for Healthcare Value Purchasing" by David Kindig, MD—a *Policy Brief* from the Wisconsin Public Health/Health Policy Institute online at <www.medsch.wisc.edu/pophealth/wphi/>:

"Health care value purchasing in the United States is a young, diverse, and growing movement in which both the private and public sectors have invested considerable financial resources and human energy. Leaders of these purchasing initiatives hope to accomplish through a variety of strategies what unmanaged market forces and regulation have failed to do: maximize the benefits of our health care system at a reasonable cost. A number of challenges might impede this development."

1. "**There is no standard conceptual or operational definition of health care value.** Typically, definitions of value center on some relationship between the cost of care and the quality or outcomes of care. A major barrier to reaching consensus on a definition for value is the lack of consensus on a definition for quality. Literally thousands of outcomes measures, indicators of care, and performance benchmarks have been developed to quantify and compare health care quality. The Institute of Medicine and the corporation-led Leapfrog Group are working to create incentives for reducing medical errors. These efforts are an important initiative in technical quality. Still, many stakeholders prefer to evaluate quality in terms of service and customer satisfaction, which are relatively easy to understand and measure, while others focus on the more elusive technical and clinical aspects of quality."

"For an emerging field, such wide variation in the underlying concept poses challenges to public understanding. The field may advance through ongoing efforts to a) seek consistent measures that will allow evaluation of efforts, b) clarify what is meant by value, and c) develop a typology of different value

definitions from which purchasers could choose and explicitly adopt."

2. "**Most value purchasing activity is targeted at reducing costs** and to some degree improving customer satisfaction, with mixed attention to technical quality or outcomes. Purchasers know how to measure and evaluate basic healthcare costs and they can get data on costs much more readily than they can on amorphous quality measures. With premiums rising at double-digit levels after several years of single-digit growth, purchaser interest in costs may increase accordingly, at the expense of quality."

3. "**The 'business case for quality' has not been made.** This term primarily relates to the impact of healthier workers on employer productivity. Many believe that the empiric literature in this area is quite weak and underdeveloped, although more is beginning to appear. Tangible return on investment from measuring and reporting on quality is not often seen. These factors inhibit many purchasers from considering quality more seriously in purchasing."

4. "**We do not know how to structure effective incentive and penalty mechanisms to ensure or improve quality.** Several initiatives have explored the use of incentives and penalties, with mixed results. But many have noted that the amounts that most employers are currently allocating to measuring or to rewarding quality is a miniscule part of health care budgets and not sufficient to create strong incentives."

Other challenges and concerns for providers, plans, and purchasers include the following:

5. "Providers and plans face multiple reporting requirements and maintain concerns about data credibility."

6. "Public sector purchasers face legislative and administrative restrictions or regulations that may impede their ability to make purely value- or market-driven decisions."

7. "Few purchasers command enough volume on their own within a given market to be effective value purchasers."

8. "As providers typically participate in multiple health plans, a single health plan may not be the effective or logistically practical organizational level for value purchasing; purchasers and consumers may require data on individual hospital or physician practices."

9. "Comparisons based on selected measures of quality or costs often invite resistance among providers, who may not agree with the measures or their interpretation."

"These challenges and barriers may be overstated. These initiatives are still in their very early development and may need more time to mature. Could a decade of improvements in measurement and standardization, combined with new lessons from additional performance improvement experiments, change the picture of value purchasing? The Institute of Medicine and the Leapfrog Coalition have brought significant public attention to patient safety and medical errors. Could this spill over into other quality and outcome areas as well? Could a 'tipping point' be achieved in which paying for health care performance becomes the norm? Could creative use of the Internet, advances in reporting and consumer education foster a new generation of consumers equipped to be their own value purchasers?"

Aspirin A Day If Doctor Says OK

From a Press Release by the Agency for Healthcare Research and Quality, 1/14/02:

"The U.S. Preventive Services Task Force (USPSTF) today strongly recommended that clinicians discuss the benefits and harms of aspirin therapy with healthy adult patients who are at increased risk of coronary heart disease (CHD), primarily heart attacks."

"Recent studies reviewed by the USPSTF found that regular use of aspirin reduced the risk of CHD by 28 percent in persons who had never had a heart attack or stroke but who were at increased risk. Those considered at increased risk for CHD are men over the age of 40, post-menopausal women, and younger persons with risk factors for CHD, (e.g., smoking, diabetes, hypertension). Every year, more than 1 million Americans die from heart attacks and other forms of CHD."

"In addition to its benefits, the Task Force also noted that aspirin can have serious side effects. Aspirin may increase the incidence of gastrointestinal bleeding and cause a small increase in the incidence of hemorrhagic strokes, which involve bleeding in the brain. Although the benefits of aspirin outweigh the harms for persons with an increased risk of CHD, the harms may exceed the benefits for those who are at average or low risk for heart disease. Rather than starting to take aspirin on their own, patients should discuss these risks and benefits with their health care professional."

Earning A Diploma Amazon Style

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. Donations are welcomed c/o: Amazon Medical Project, Inc., 106 Brodhead St., Mazomanie, WI 53560. AMP is a non-profit, tax-exempt organization.

"Ever since beginning to work with Juvencio in late 1992, and realizing what a sponge he was for learning, I have been looking for some way to get him the recognition he deserves. He can tend to meningitis, malaria, poisonous snakebites, intravenous rehydration, and machete cuts, he can pull teeth, he knows sterile technique (important for assisting me during surgical procedures), he reads our malaria slides, and much, much more. Since Edemita began at the clinic in 1995, quickly taking over all triage, gathering of histories and vital signs and basic exams, Family Planning, the vaccine program, cleaning and filing and much, much more, I have wanted the same for her."

"There are also practical reasons for accrediting them if I am to succeed in my goal of making the clinic more independent of me. We may or may not have other physicians working during my absences, but Juvencio and Edemita will always be around, and will have a good deal of the responsibility, even if there is a physician filling in for me."

"The thing is, neither of them has any more than a grade school education, i.e., six years in a one-room school on the edge of the Amazon River. In this country where red tape is a cult unto itself and degrees, certificates, and titles are highly valued for their own sake as well as for the fact that they offer some sort of assurance that the person holding them really does have some level of skill—as opposed to the many people who are out there practicing in various professional fields who don't actually have any training in those fields (including many pseudo-medical practitioners)—well, it seemed highly unlikely that I would ever be able to achieve any sort of equivalency degree for either of them. Furthermore, although Peru agrees that I am a physician (those of you familiar with these letters may recall that seven-year odyssey), I have no qualifications either real or imagined as a teacher."

"What we really need is something granted 'En la Nombre de la Nacion' ('In the Name of the Nation'), which is the designation at the top of the paper that signifies that the diploma has come from one of the government-sponsored national universities."

"The Universidad Nacional de la Amazonia Peruana (UNAP, a government university at the national level with a branch in Iquitos), in conjunction with the Ministry of Health, decided to offer a course which would result in a university-level degree in nursing, roughly equivalent to an LPN degree in the U.S., to those with clinical experience but little or no formal training. So what were the qualifying requirements?—Well, of course there was the person's high school diploma, and then their nursing courses. Wait a minute, I said, I thought this was for people who didn't have those things.—O, well, we could use the newly issued certificates in lieu of them. Ok, now we're on track. What else?—the usual: several photos of each applicant, copies of their identification documents, a stack of papers applying for the course, and payment of fees amounting to about $275 per person, in installments at the national bank."

"I returned triumphantly to Yanamono and instructed Juvencio and Eda to get their photos taken and their papers together, went to the bank to stand in line and make the first of the payments, then returned to the hospital to the office of the person in charge of setting up this course. She told me that the course would last eight months, that it would be in four modules, that it would be primarily a correspondence course except for a few days at the beginning where everyone would gather to be oriented and then a few more days every two months to take the tests for each module, and that it would begin in August, 2000 and terminate in May, 2001."

"The course did not actually get underway until sometime in October, and the 'few days' of orientation turned into requirements to go to the city a couple of times a month for orientation, class discussions, tests, and so forth. The course directors always had a little difficulty in coordinating between the instructors of the written portion of the course, and the instructors of the practical part. One round of testing was scheduled

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for Thursday, meaning that Juvencio and Eda had to leave early on Wednesday to get to the city on the river taxis. The written test was administered Thursday morning as planned, but the students were told to come back on Monday for the practicals, so Friday they returned to Yanamono, leaving again on Sunday to take the test on Monday and come home again on Tuesday, making a total of a full week to take one day's worth of tests."

"And of course there is the usual emphasis on form, no matter what the content … they took the first of the written assignments in to Iquitos, only to be told that handwritten work was not acceptable; the work had to be done on a computer. Fortunately, around every school in Iquitos, there are young people who make their living typing papers on the computer, complete with fancy cover sheets and all the rest."

"The last course requirement was that the students write a 'monograph,' basically a term paper. This course allegedly designed for people living along the Amazon River, had as one of its requirements that the monograph be written using sources gleaned through the Internet!"

"None of this got started until early June (remember, the course had been scheduled to finish in May, but due to teachers' strikes and general procrastination, the course work had barely been done by then, let alone the monographs), and by July 4, while you were perhaps watching fireworks, I was busy making enlarged copies of grim photographs out of textbooks, showing Ascaris lumbricoides worms poking their ugly heads out of appendixes, or blocking intestines by forming balls of dozens of worms; and then cutting these copies carefully and typing captions to go with them and cutting the captions and pasting them all onto clean sheets of paper so that I could make final photographs of all the carnage. (They had selected Ascaris lumbricoides, the major intestinal parasite around here, as the topic for their paper.)…" *to be continued…*

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