

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

Rural Health Can Help Lead The Way

From a Guest Editorial by Tim Size, RWHC Executive Director, for the *Wisconsin Medical Journal* (vol. 101, no. 5). This current issue is dedicated to "Wisconsin's Rural Health Landscape" and is available at <www.wisconsinmedicalsociety.org/>:

"Rural health, both clinically and administratively, has always been a great field in which to work. Addressing above average challenges with below average resources means that the work stays challenging. The smaller scale of most rural health organizations allows for more opportunities to generalize, to appreciate the linkages among a diverse array of practices and issues. Innovation has always been easier in smaller, less bureaucratic organizations. Rural people have traditionally appreciated the value of individual relationships and institutional collaboration within the community. Now, we are beginning to understand that rural health is also playing a key role in helping to transform the American health care 'system.' Where but in rural health is more done with less? Taken as a whole, where do the 'demographics' look more like the American future than in our rural communities? **Rural health care presents an important opportunity to better understand how to deliver cost-effective care under challenging circumstances.**"

"Rural communities have long struggled with many of the same issues that the nation as a whole is beginning to experience. As the enclosed 'National Rural

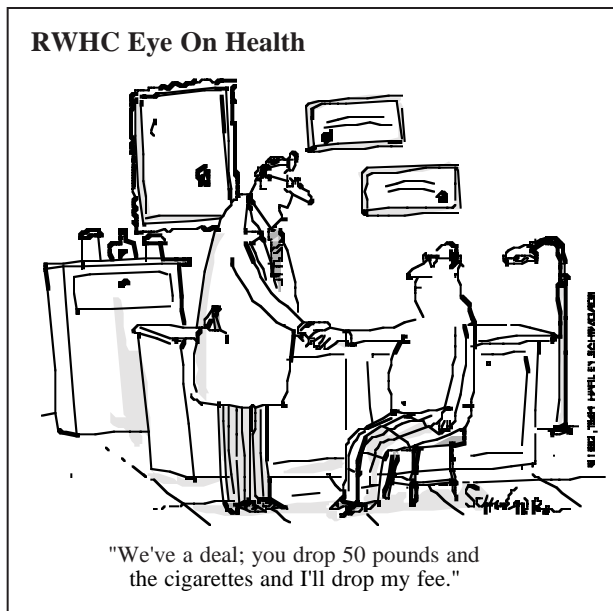
Health Snapshot' shows, rural America is older, poorer and often sicker. There is much to be proud about in rural America but it is clearly not exempt from the national epidemics of drugs, smoking, junk food and just plain sitting. Perhaps most disturbing, is the fact that the mortality rate of rural youth is a third higher for both males and females compared to the central cities. If rural America ever was 'Lake Wobegone,' those days are over."

"Rural communities face these needs with a health care system that has long had funding significantly below that available in urban and suburban communities. Whether intentional or not, Medicare's historic anti-rural bias has been the driving force in the chronic under payment and investment in rural health. Rural communities have had to learn to do more with less."

"There is growing agreement, if not already a consensus, that our American health care system is headed for a 'train wreck'—that the key demographic, technological and cost trend lines inevitably lead to a system that is, under even the most optimistic funding scenarios, unsustainable. For small employers and self-

employed people, the American future has already arrived in the form of rapidly declining access to affordable health insurance, with benefits not much more than protection of their assets from the expense of a catastrophic medical event. In rural communities, this phenomenon is accelerated by an additional double punch. Medicare payment shortfalls well above the national average are forced on a labor force with a ratio of workers to elderly well below the national average."

RWHC Eye On Health



A National Rural Health Snapshot	Rural	Urban
Percentage Of USA Population	20%	80%
Percentage Of USA Physicians	11%	89%
Percentage Of Physicians In Primary Care	54%	38%
Population Aged 65 Or Older	18%	15%
Population Below Poverty	14%	11%
Average Per Capita Income	\$19K	\$26K
Population Who Are Non-Hispanic Whites	83%	69%
Adults Describe Health Status As Fair/Poor	28%	21%
Obese Men Over Age Of 18	22%	18%
Adolescents (Age 12-17) Who Smoke	19%	11%
Male Death Rate Per 100,000 (Ages 1-24)	80	60
Female Death Rate Per 100,000 (Ages 1-24)	40	30
Population Covered By Private Insurance	64%	69%
Population who are Medicare Beneficiaries	23%	20%
Medicare Beneficiaries Without Drug Coverage	45%	31%
Medicare Spends Per Capita To USA Average	85%	106%
Medicare Hospital Payment-To-Cost Ratio	90%	100%
Percentage Of Poor Covered By Medicaid	45%	49%
<p>Note: Urban is defined as Metropolitan Statistical Area except for Health Status, Smoking & Death Rates, where it is defined as “core metropolitan areas” or “metro large central.”</p> <p>Data: Rural Information Center Health Service (RICHS), 6/02 Urban and Rural Health Chartbook in Health, United States, 2001 <i>Medicare Statistical Supplement For 2000</i> <i>MedPAC Report To The Congress, March, 2001</i></p> <p>Graph: RWHC, 7/02</p>		

between ‘efficiency’ and ‘choice.’ What I am saying is that we have an opportunity to learn and experiment until the political log jam breaks—that now and then we can find key elements already in play and that we will find many of these solutions in rural communities. (The Robert Wood Johnson Foundation has recently funded just such a rural study with investigators at the University of Washington and the University of Minnesota.)”

“To meet future demands for quality, cost effective health care, I believe America’s future health care ‘system’ and health professionals are highly likely to make greater use of these current rural best practices:

1. Fostering long term partnerships with patients, families, and community
2. Addressing both individual and community determinants of health
3. Understanding the challenge of competitive forces without being subordinated by them
4. Cooperating both within and between communities
5. Balancing preventative, primary and specialty care
6. Balancing the art and science of medicine and health
7. Adopting new technology as needed rather than as expected.”

“The barriers in both rural and urban communities for wider spread adoption of these best practices are clearly numerous and substantive. But we can better overcome them and prepare for the future by more closely looking at how those communities with the greatest challenges are working, and in many cases succeeding, today.”

Tommy Thompson’s Real Rural Legacy?

From “Opportunities For Rural Community Partnerships” by Tim Size at the Summit On Rural America to help “roll out” Secretary Tommy Thompson’s Rural Initiative, Denver, Colorado; 7/26/02:

“Secretary Thompson’s Rural Initiative to restructure the Department of Health and Human Service’s

“My favorite definition of being ‘cognitively challenged’ is doing the same thing over and over again and expecting a different result. (As someone who could fairly be described in many arenas as a ‘traditionalist,’ I do not exempt myself from this critique.) No field has as many creative, dedicated individuals doing excellent work as does health care; but when addressing the ‘big picture,’ we typically orbit in a perpetual debate of overly familiar arguments and counter arguments. Both the ‘Canadian Health Will Solve All Problems Advocates’ and the ‘I’ll Die With My Boots On Free Marketeers’ are the prime polar examples.”

“If you expect me to predict when and how ‘The American Health Care System’ will be healed, you will be disappointed. There are no ready answers that will easily move us past our current health policy gridlock

(HHS) management of its rural portfolio is right on the target. **While new federal dollars are needed and welcomed, this proposal is fundamentally a major shift in how HHS thinks and works.** As a past President of the National Rural Health Association and past member of the Secretary's National Advisory Committee on Rural Health, I am convinced that only cross-sector, integrated approaches can fundamentally make a difference. This is true in our communities, in our state capitals and in Washington."

"The Cooperative is owned and operated by twenty-eight rural community hospitals in southern and central Wisconsin. We have worked to be a catalyst for regional collaboration—an aggressive and creative force on behalf of rural communities and rural health since 1979. In the limited time available, I can't talk about all of our failures and successes. In trying to work across traditional boundaries there are many current RWHC activities relevant to the Secretary's Rural Initiative; HIPAA, managed care, telehealth and bioterrorism preparedness are a few examples."

"I will briefly comment on three particularly good examples of cross-sector, multi-community collaboration: (1) economic development, (2) public and private benefit program outreach and (3) agricultural health and safety."

Rural Health & Economic Development

"I particularly appreciated seeing the Secretary's emphasis on the connection between rural health and economic and community development. The RWHC office is in Sauk County. In only this one rural county, the healthcare sector, with its direct and indirect impact, creates employment for 4,400 people and \$128 million in personal income. We have long believed that making the public aware of the importance of a strong local health care sector by encouraging appropriate use of local hospital and health care facilities will help ensure that the health care sector in rural counties remain strong for many years to come. The core message is:

- Every 2 dollars of revenue generated by the health care sector will generate an additional dollar of revenue in other Sauk County industries.
- Every two jobs created (or lost) in the Sauk County health care sector 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 sector creates 30 cents

worth of personal income in other county industries."

"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 health care sector not only helps to attract and maintain other businesses but makes a major economic contribution in its own right. 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 and vice versa. Understanding these changes allows the country to better plan for changes in both health and other sectors, maximizing the positive impacts of these changes and minimizing negative ones."

"This thinking is not new. For over ten years, Wisconsin's top State Board responsible for rural health issues has been located in the Department of Development, allowing for an ongoing process of cross fertilization between rural health leaders and state economic development initiatives. In turn this has helped lead to Competitive Wisconsin, Inc., a consortia of business, labor and government, making ongoing geographic inequities in the Medicare program one of their high priority public policy issues for 2002-03. In Wisconsin, business leadership now understands that Medicare underpayment is a significant component of their health care insurance premium."

On Site Benefits Counseling

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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“Rural communities, for a variety of reasons, have typically not been as successful in connecting eligible families to enrollment in government programs or to provide families with the professional support they need to negotiate payment hurdles within private insurance plans. More families could be covered, and more provider bills could be paid, but too many families are unequipped to take advantage of available public and private benefit programs. The effect is staggering bills for families and bad debt for providers.”

“To create a ‘win-win’ for families and rural hospitals, RWHC has developed a partnership with ABC for Health, Inc. whose family health benefits counselors are well versed with the ins and outs of the state’s Medicaid Program and are able to help families negotiate the red tape and get the care they need. In doing so they will bring needed health care coverage to scores of rural families and will bring to the rural hospitals payment for scores of charges.”

“This project will bring experienced benefits counselors into the hospital billing or business office to train local staff and integrate effective health care financing protocols as a function of customer service. While several larger urban clinics and hospitals around the state have developed Benefits Counseling programming, rural hospitals have largely been unable to provide the initial support to get the program off the ground. These counselors would be integrated within the services and culture of each facility through existing offices, integrated with the rest of the network and integrated with the community and local human service agencies through the nascent HealthWatchWisconsin network. Networking enables several facilities to take relatively safe steps forward yet experience dramatic gains through a more rapid implementation and learning curve.”

“With the benefit of a broad Medicaid and SCHIP program this project will enroll scores of children, pregnant women and parents in health care coverage programs. Along with enhanced abilities to cut through insurance delays and denials, this will increase revenues at network partner hospitals while helping them put on an even more patient-friendly face.

Health care access will be enhanced, as will be the financial viability of participating hospitals.”

“To implement this partnership, ABC for Health and RWHC unsuccessfully competed for a federal Network Development Grant in 2002. Subsequently, with particularly creative assistance from ABC for Health, we have been able to design a self-funded approach to initiate this program with a significant number of RWHC hospitals.”

Serving An Overlooked Minority

“According to Dr. Roger Williams at the University of Wisconsin, most Wisconsin farmers have experienced chronic, prolonged stress over the last 15+ years. Farmers who are under stress for long periods of time encounter a broad array of negative physical, mental, behavioral and cognitive symptoms or problems.”

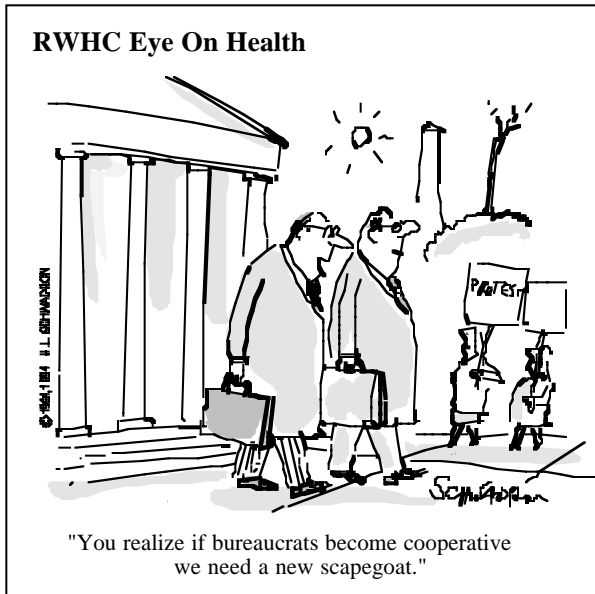
“Dr Williams goes on to say that “The combination of effects will be different for every farm family member. But many experience a deadly combination of anxiety, sleep disturbances, exhaustion, anger, depression,

substance abuse, withdrawal from others, as well as cognitive and self-esteem problems. It creates a situation where harm of self and others is a real possibility. The other common problem in farm families that have experienced chronic, prolonged stress is marital and family problems: the stress drives a wedge between family members, often leading to a downward spiral of less communication, more frequent fights and greater isolation within the family. This downward spiral is often accentuated when one or both spouses work off the farm to create a stronger

cash flow situation for the family; the off-farm job(s) drives the wedge deeper and communication becomes even more strained.’ “

“The health, mental health and safety issues of farmers can be summarized as follows and clearly need the collaborative interventions from health and social service providers:

- Exhausted and sleep deprived
- No health insurance or underinsured
- At risk without disability insurance



- Don't seek treatment for minor accidents or chronic conditions
- Don't seek counseling for mental health problems
- Counselors don't understand the farm culture
- Lack of access to doctors and hospitals."

"To try and provide better services in a three county area a consortium of five RWHC hospitals, three public health departments, Wisconsin's Office of Rural Health and the Southwest Area Health Education Center joined RWHC in initiating a pilot program known as Partners in Agricultural Health. Financial support was obtained through the federal Office of Rural Health Policy's Outreach Grant Program."

"From a recent article in the *Wisconsin State Farmer*: 'Partners in Agricultural Health works together with existing community and regional services and is focused on developing awareness of specialized services for farm-related health concerns. These include health education and health promotion programs. They also provide information on personal protective equipment such as respirators and information on how to get them and how to use them.' "

"Through this program, rural people have an opportunity for first-responder training, first-aid training, programs detailing respiratory hazards on the farm and ways to prevent hearing losses for those who work on farms. Rural residents also have an opportunity to take part in various health-screening services such as hearing tests, lung function tests, height and weight evaluation, blood pressure screening, respirator education and fitness tests, cancer self-examination, and instruction on the proper techniques for lifting to prevent back injuries.' "

Summary

"Rural communities need a fundamentally new federal relationship if they are to prevail over an intimidating array of major challenges. As noted above, we have many great opportunities where we can be more effective if we grow beyond our traditional "professional silos." We appreciate Secretary Thompson's ongoing leadership in moving HHS in the same direction."

Real Solutions Look At Big Picture

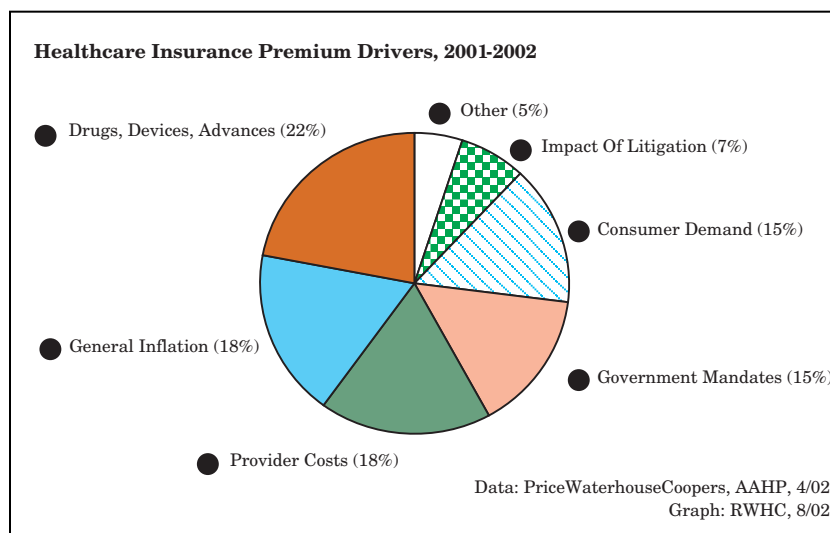
From "Healthcare Industry Review and Outlook," a May 2002 Bank of America Research Brief, 5/02:

"On April 24, the American Association of Health Plans released a new study detailing the causes of higher health insurance premiums and higher health costs in general. Overall, the study by PriceWaterhouseCoopers (PWC) entitled, 'The Factors Fueling Rising Healthcare Costs,' reports that the overall increase in health insurance premiums between 2001 and 2002 was 13.7%. The report details six major areas causing increased healthcare costs."

"Drugs, Medical Devices and Medical Advances—This category represents roughly 3.0% of the increase in premiums (**22% of the total increase**). While it comes as no surprise to us that drugs and medical devices would account for a significant share of cost increases, the report points out a new area of rapidly increasing costs—diagnostic imaging. The number of diagnostic imaging procedures is growing rapidly at almost 9% per year, with much of the increase coming in higher cost modalities such as PET, MRI and PET/CT combinations. While drug costs continue to rise rapidly, the rate of increases has been slowed recently as insurers' efforts to implement multi-tiered co-payments has shown some success."

"General Inflation—Economy-wide inflation also contributes about 2.5% (or **18% of the total**) to the rise in health premiums. The overall CPI inflation rate has been fairly modest over the past 5–6 years, but still contributes to the healthcare inflation rate."

"Rising Provider Costs—The report estimates that rising provider costs account for 2.5% of the healthcare premium increase (**18% of the total**). Much of the increase is attributed to



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comprised of RWHC and UW representatives,
reserves the right to not award the Prize.*

stronger negotiating clout on the part of hospitals in many markets. In addition, most providers have moved away from risk-sharing or capitated arrangements. We continue to see hospitals, both for-profit and not-for-profit systems, demanding much larger payment increases from health insurers and, in most cases, they have been successful."

"Government Mandates and Regulations—The report estimates that roughly 2.0% (**15% of the total**) of health premium increases is related to government mandates and regulation. This category includes state-mandated benefits, such as chemical dependency treatment coverage, dental coverage and maternity hospitalization. The report estimates that there are 1,500 mandated health benefits at the state and federal levels. In addition, this category includes other healthcare regulatory costs, such as HIPAA privacy and electronic claims standardization regulations."

"Increased Consumer Demand—The aging of the population and increased demand for new drugs and technologies account for roughly 2.0% of the health premium increases (**15% of the total**). We expect this to become an even more important driver over the next ten years, as more baby boomers retire and begin to use more healthcare services."

"Impact of Litigation—Approximately 1.0% (**7% of the total**) of the rise in premiums is related to litigation and risk management costs. Specifically, PWC esti-

mates that class-action lawsuits and malpractice awards have led to an increase in defensive medicine, which has driven up healthcare costs and utilization. Malpractice insurance costs for physicians, hospitals and other providers is now rising 20%–100%, as one of the largest malpractice insurers, St. Paul Cos., has exited the business."

"Fraud and Abuse and Other Costs—Approximately 1.0% (**5% of the total**) of health premium increases is related to Fraud and Abuse and Other Costs."

Current Dental Crisis Worsening

From a Wisconsin Primary Health Care Association study released on August 15th; the complete report is available at <www.wphca.org/>:

"This report describes the many attributes of Wisconsin dentists based on self-reported survey data collected in Spring 2001. The survey count of active dentists in Wisconsin (2,842) was very close to estimates by the ADA (2,890 in 1998); thus, the survey captured most Wisconsin dentists. Major findings are described below."

Supply of Dentists in Wisconsin

"State Supply. In Wisconsin, there were 53 dentists per 100,000 people, or one dentist per almost 1,900 people. The national average was 59 dentists per 100,000 people. Thus, the Wisconsin supply ranks fairly well among states, but is below the national average."

"Dentist Distribution Across Wisconsin. The supply of dentists varied across regions of the state. The greater Milwaukee area and other metropolitan areas had a substantially higher supply than rural areas. In addition to an overall low dentist supply, rural areas also had a much lower supply of specialists."

"Pediatric Dentists. Of specific concern for children's access to oral health care was the low number of pediatric dentists and their concentration in metropolitan areas, particularly the Southeastern region."

Characteristics of Wisconsin Dentists

"Dental School Attended. A majority (70%) of Wisconsin dentists attended the only dental school in Wisconsin (Marquette University School of Dentistry in Milwaukee). Substantial numbers graduated from schools in neighboring states: Minnesota, 11%; Illinois, 7%; and Iowa, 5%. The out-of-state dentists were

more likely to be more recent graduates, practice as specialists, and participate in Medicaid. The practice locations of graduates from neighboring states were more often in rural areas.”

“Rural Issues. As stated above, overall dentist supply, as well as the supply of dental specialists, was low in rural areas. Access to dental care is likely difficult for rural residents regardless of insurance status. Interestingly, despite being fewer in number and accepting fewer new patients, more rural dentists reported treating Medicaid patients than metro-central and metro-other dentists.”

Dentist Medicaid Participation

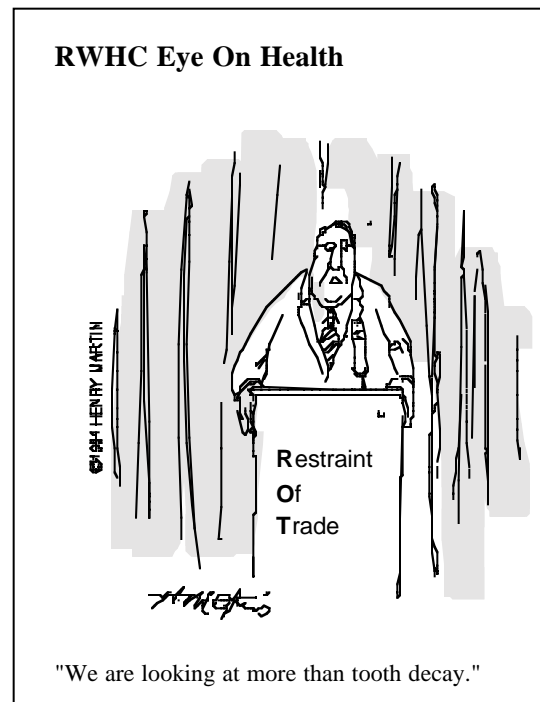
“Findings from this study showed important differences in Medicaid participation based on dentist characteristics and practice location, both of which impact current and future access to dental care for Medicaid enrollees. While 42% of dentists reported treating Medicaid patients, only 20% of dentists reported that they would accept new Medicaid patients. Participation was highest in the rural areas (similar to what was found in the Illinois study, described above). Participation was also high in the Southern and Western regions, where dentist supply was lowest. In the Southeastern region, where 86% of dentists were in-state graduates, Medicaid participation was lowest. In fact, by region, participation was lowest for in-state graduates practicing in the Southeastern region (29%) compared to in-state graduates practicing in other regions. Also, pediatric dentists were most likely to participate in Medicaid, although there were few of them.”

“Our current aggregate estimate is that the 946 primary care dentists who reported treating Medicaid patients would each have to treat 123 Medicaid patients to maintain the 23% utilization reported in FY 2000 by the State. Projections of the number of Medicaid enrollees each dentist would need to treat, based on varying utilization levels, indicate that the current dentist workforce is insufficient to care for the Medicaid population. For example, to meet the Healthy People 2010 objective of 57% of low-income children receiving preventive dental care, each currently participating primary care dentist would need to treat 306 Medicaid enrollees annually (6/week). At 2 visits per enrollee per year, this constitutes between 16% and 23% of all

annual patient visits. Historically, dentists have not participated at these levels. Given the trend in increased Medicaid enrollment, the current level of dentist participation in Medicaid is insufficient to maintain current utilization levels (23% in FY 2000) much less increase utilization rates for Medicaid enrollees.”

Dentist Retirement Plans

“Wisconsin dentists reported on their plans for retiring or leaving practice and indicated substantial attrition in the next 5 to 10 years. Almost 1 in 7 (433) dentists planned to retire or leave practice in the next 5 years, and about 1 in 3 (996) reported the same in the next 10 years. Based on estimates of new dentists from the WDA study, this represents a net loss of 153 dentists in 5 years and 436 dentists in 10 years. In addition, Medicaid participation will be affected by dentists’ retirement plans.”



Informal Caregivers Key Part Of Workforce

From “Challenged To Care: Informal Caregivers In A Changing Health System Social Policy Must Respond To What Caregivers Are Telling Us About Their Experiences.” by Karen Donelan et al in *Health Affairs*, July/August, 2002:

“Each year 23 percent of Americans provide unpaid assistance to ill, disabled, or elderly persons. Most caregivers (71 percent) do not live with care recipients. Primary caregivers provide more care of all types. Non-primary caregivers also provide substantial care and services. Caregivers perform complex medical tasks, including medication administration, and errors can result. Few receive assistance from paid professionals or aides because of quality or financial concerns. In many areas, support and instruction could lighten caregivers’ burdens and help to ensure high-quality care at home.”

This report was from 1998 national survey of 1,002 informal caregivers funded by the Kaiser Family Foundation. A Chartbook from the Foundation, illustrating the survey results, is available at <www.kff.org/.

“From the Chartbook: ‘Why is the Caregiver Helping?’ Informal caregiving fills in the gaps in long-term care. Often the kind of care a person needs does not require skilled nursing care, but is more personal in nature. Over forty percent say the reason they are helping is because professional help was not required. And over a third (37%) say that the person who needs help didn’t want to have strangers in their home. However 40% of caregivers report that the reason they are helping their family member or friend is because that person could not afford to pay for outside assistance.”

Cooperation Is Smarter Than We Thought

From “Why We’re So Nice: We’re Wired to Cooperate” by N. Angier in *The New York Times*, 7/23/02:

“Hard as it may be to believe in these days of infectious greed and sabers unsheathed, scientists have discovered that the small, brave act of cooperating with another person, of choosing trust over cynicism, generosity over selfishness, makes the brain light up with quiet joy.”

“Studying neural activity in young women who were

playing a classic laboratory game called the Prisoner’s Dilemma, in which participants can select from a number of greedy or cooperative strategies as they pursue financial gain, researchers found that when the women chose mutualism over ‘me-ism,’ the mental circuitry normally associated with reward-seeking behavior swelled to life.”

“And the longer the women engaged in a cooperative strategy, the more strongly flowed the blood to the pathways of pleasure. ‘The results were really surprising to us,’ said Dr. Gregory S. Berns, a psychiatrist and an author on the new report, which appears in the current issue of the journal *Neuron*. ‘We went in expecting the opposite.’ “

“Instead, the brightest signals arose in cooperative alliances and in those neighborhoods of the brain already known to respond to desserts, pictures of pretty faces, money, cocaine and any number of licit or illicit delights. ‘It’s reassuring,’ Dr. Berns said. ‘In some ways, it says that we’re wired to cooperate with each other.’ “

“The study is among the first to use M.R.I. technology to examine social interactions in real time, as opposed to taking brain images while subjects stared at static pictures or thought-prescribed thoughts.”

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