

Review & Commentary on Health Policy Issues for a Rural Perspective – April 1st, 2003

Our Communities Feel Medicare Shortchange

From “Busting Budgetary Illusions” by David S. Broder in *The Washington Post*, 3/03 and the lead editorial in the 3/10-16 national edition:

“This year is not routine in terms of the belt-tightening needed in Washington to accommodate the president’s big increases in military and homeland defense spending and still stay within his overall target of a 4 percent increase in discretionary spending.”

“And when you factor in what is happening in states and cities, it becomes clear that hard choices are being made about programs that directly affect people’s lives.”

“One day last week, I had a visit from Philip Ennen, the vice president of Community Hospitals of Williams County, Ohio. He was in Washington to add his voice to those of other rural hospital administrators who complain that Medicare reimbursement payments—set lower for them than for big-city hospitals—have become a crippling problem.”

“The shortfalls in federal Medicare payments mean that costs are ‘shifted onto local businesses, industries, commercial payers and the working

poor, who are mostly self-insured,’ Ennen told me. Local firms in Bryan, Ohio, often are owned by conglomerates headquartered in distant cities, he said, and when the green-eyeshade executives at headquarters see how disproportionately high the health care costs are in cities such as Bryan, those plants and their jobs become vulnerable.”

“Thus, budgetary economies affect whole communities, not just hospitals.”

“My next visitors were leaders of child advocacy groups from Arizona, Illinois and Missouri, in town for a meeting of their national association, Voices for America’s Children. They described in measured but dead-serious tones what the combination of state budget crunches and Bush’s recommended spending restrictions are doing.

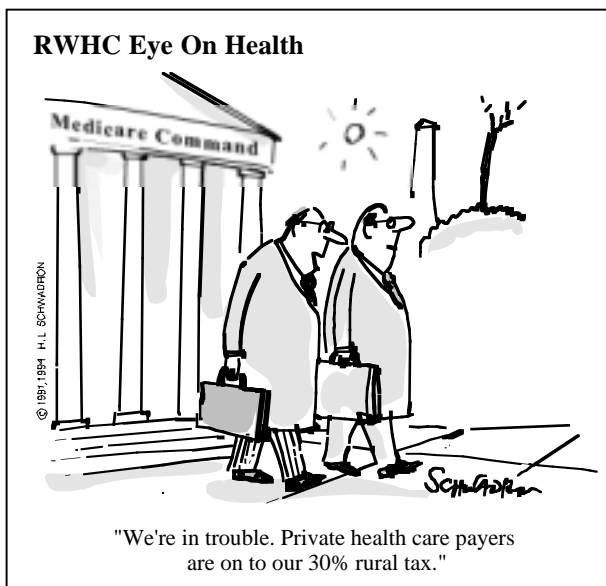
“‘I have been doing this for 25 years,’ said Carol Kamin of Arizona, ‘and I have never seen the situation as dire.’ She and her counterparts talked about the reductions that are looming in health insurance

for children, in day-care services for those whose mothers have moved off welfare, and in preschool programs.”

“The message from all of them: The gains that have been made, slowly and painfully in the past decade, may well be reversed now.”

“Schools do not exist to promote war, peace or any other national initiative. Their first job is to help Americans analyze these choices for themselves.” Jonathan Zimmerman (teaches history & education at NYU) 3/03.

RWHC *Eye On Health*, 3/29/03



STOP The Proposed Elimination Of Wisconsin Medicaid Rural Equity Payments

- The two million dollars per year from the Wisconsin Medicaid program's so called "Rural Hospital Adjustment" goes to small rural hospitals with the state's lowest total operating margins.
- The proposed elimination of the Medicaid Rural Adjustment disproportionately hits a few hospitals who are already facing major financial challenges to keep their doors open; the loss ranges from 5% to 23% of what would be their base Medicaid inpatient payment.
- Even with the "adjustment", these small rural hospitals are losing over 20 cents on every dollar expended for Medicaid patients.
- Like some other adjustments, this is not an "icing on the cake" but intended as a critically needed equity payment for the Federal and State governments' use of a flawed, anti-rural MEDICARE wage index.
- This adjustment has allowed the State, for its own convenience, to use the anti-rural Federal Medicare wage index in order to avoid developing one on its own. This is the same index that significantly contributes to Wisconsin's Billion Dollar A Year Medicare Shortfall.

WI Small Employer Pool: Fish Or Cut Bait

The following is from a letter to Governor Jim Doyle and the Wisconsin Legislature by Eric O. Stanchfield, Secretary of the Department of Employee Trust Funds, and Tim Size, Chair of the Private Employer Health Care Coverage Program Board, dated 3/23/03:

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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"Rick Curtis, President of the Institute for Health Policy Solutions (IHPS), has provided us a report citing those conditions that are necessary to implement the Private Employer Health Care Coverage Program (PEHCCP). Mr. Curtis and the staff at IHPS are considered to be some of the nation's leading experts on the development and operation of health care purchasing coalitions. IHPS was asked by the Department and the PEHCCP Board to study the situation in Wisconsin and develop recommendations on what changes were required to begin operation of this program." (A summary of the preliminary report is available in the February issue of this newsletter and the final report can be found at <http://etf.wi.gov/>.)

"The report suggests three strategies, either alone or together, that offer the best, and perhaps only, hope for successful implementation of the program:

- Small Group Market Rating Reforms – moving to a modified community rating system where the only variation allowed for premium rates charged to small groups would be due to size, age and geography.
- Extending Coverage to the Uninsured and Making Coverage More Affordable for Small Employers – providing subsidies for those obtaining coverage through the pool.

- The Pool IS the Small Employer Health Insurance Market—requiring that all health insurance sold to small employers be sold only through the pool.”

“The PEHCCP Board and the Department believe that one of these changes must be accomplished or the program can never be implemented. **Therefore, we ask that if the Legislature wants the Department to proceed, changes in the law must be pursued now. If these changes are not to be pursued, we ask that the law creating the program be repealed, the PEHCCP Board be disbanded, and the funds for the program’s operation be returned to the general fund.**”

Wisconsin Adopts Population Health Focus

The Wisconsin Turning Point Initiative (a multi-year, statewide public-private planning effort) recently published its implementation plan, “Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public” (see box below). “Population health” concepts dominate the report.

In 1999, Blue Cross/Blue Shield United of Wisconsin (BC/BS) announced its intention to convert to a for-profit corporation and to distribute the proceeds from

the sale of its stock to the UW Medical School and the Medical College of Wisconsin to advance the health of the state’s residents. The recently released draft plan by the UW re ‘their share’ of these monies places a heavy emphasis on improving Wisconsin’s “population health.”

The bottom line is that we need to substantially improve our understanding of “population health.” To help with this process, the following is offered from “What Is Population Health?” by David Kindig and Greg Stoddart, published in the March, 2003 edition of the American Journal of Public Health. David Kindig is with the Department of Population Health Sciences, University of Wisconsin—Madison School of Medicine. Greg Stoddart is with the Department of Clinical Epidemiology and Biostatistics, McMaster University Health Science Centre in Ontario:

“Although the term ‘population health’ has been more commonly used in Canada than in the United States, a precise definition has not been agreed upon even in Canada, where the concept it denotes has gained some prominence. Probably the most influential contribution to the development of the population health approach is Evans, Barer, and Marmor’s *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, which grew out of the work of the Population Health Program of the Canadian Institute for Advanced Research. No concise definition of the term is included, the authors state the concept’s ‘linking thread is the common focus on trying to understand the determinants of health of populations.’ ”

“Recently, even in the United States, the term is being more widely used, but often without clarification of its meaning and definition. While this development might be seen as a useful movement in a new and positive direction, increased use without precision of meaning could threaten to render the term more confusing than helpful, as may already be the case with ‘community health’ or ‘quality of medical care.’ For this reason, we propose a definition that may have a more precise meaning for policymakers and academics alike; our purpose is to stimulate active critiques and debate that may lead to further clarification and uniformity of use.”

What You Can Do To Improve Population Health

From Ken Baldwin, Administrator, WI Division of Public Health:

1. Go to the below Web sites and become familiar with the recently adopted Wisconsin plan.
2. Share the plan in your networks and use them while you are out-reaching to traditional and new partners in your communities.
3. Contact your local health department and offer to partner.
4. Contact Margaret Schmelzer schmemo@dhfs.state.wi.us and let her know how your organization will have sustained engagement in *Healthiest Wisconsin 2010*, how you will engage your partners, and what ideas you have that will make a difference locally and statewide.

www.dhfs.state.wi.us/Health/StateHealthPlan/
copy of "Healthiest Wisconsin 2010"

www.dhfs.state.wi.us/Health/StateHealthPlan/ImplementationPlan/
copies of the Implementation Plans”

“As indicated above, the primary tension or confusion at present seems to be between defining population health as a field of study of health determinants or as a concept of health. The Group Health Community Foundation has stated that ‘some observers see population health as a new term that highlights the influential role of social and economic forces in combination with biological and environmental factors, that shape the health of entire populations; others interpret population health primarily as a goal—a goal of achieving measurable improvements in the health of a defined population.’ ”

“We propose that *population health as a concept of health* be defined as ‘the health outcomes of a group of individuals, including the distribution of such outcomes within the group.’ These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners. Such populations are of relevance to policymakers. In addition, many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level.”

“Defining population health this way requires some measure(s) of health outcomes of populations, including their distribution throughout the population. We chose the broader term ‘health outcomes’ rather than the more narrow term ‘health status’; we believe the latter refers to health at a point in time rather than over a period of years. We do not believe that there is any one definitive measure, but we argue that the development and validation of such measures for different purposes is a critical task for the field of population health research.”

“Our definition does imply the necessity of one or more broad summary measures capable of being a dependent variable for the spectrum of all determinants (generally including length of life and health-related quality and function of those life years), along

Wisconsin’s Shame Family Medicine Residencies Sit Empty

Wisconsin ranking re the percent of Family Medicine residencies filled in 2003 was 8th from last place (versus 6th last year). But before you celebrate, recognize that this is because Wisconsin’s rate only fell from 61% to 60% while the national rate fell from 79% to 76%.

Regardless of all the rhetoric to the contrary, Wisconsin’s two medical schools have a long way to go to create an admissions process and educational environment that nurtures graduates to help meet our state’s need for rural primary care physicians. When will they begin to be held accountable?

with a family of other submeasures for different policy and research purposes. For example, the Health Utilities Index is being used in the Canadian National Population Health Survey, Years of Healthy Life have been used in Healthy People 2000, and the EuroQuol has been added to the Medical Expenditure Panel Survey.”

“We support the idea that a hallmark of *the field of population health* is significant attention to the multiple determinants of such health outcomes, however measured. These determinants include medical care, public health interventions, aspects of the social environment (income, education, employment, social support, culture) and of the physical environment (urban design, clean air and water), genetics, and individual behavior. We note with caution that such a list of categories can lead to a view that they operate independently; population health research is fundamentally concerned about the interactions between them, and we prefer to refer to ‘patterns’ of determinants.”

“In our view, a population health perspective requires attention to the resource allocation issues involved in linking determinants to outcomes. Part of the study of population health involves the estimation of the cross-sectoral cost-effectiveness of different types and combinations of investments for producing

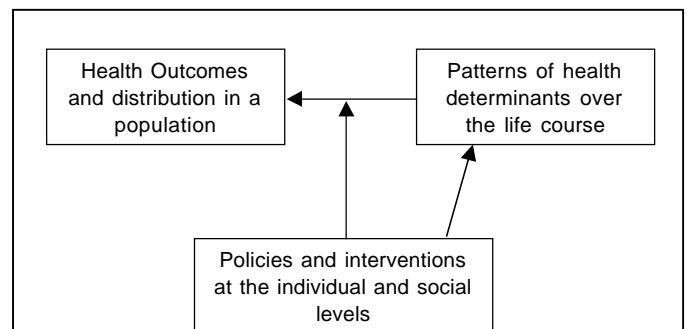


Figure 1-A schematic definition of the field of population health

Original Figure: AJPH, 3/03
Adapted Figure: RWHC, 3/03

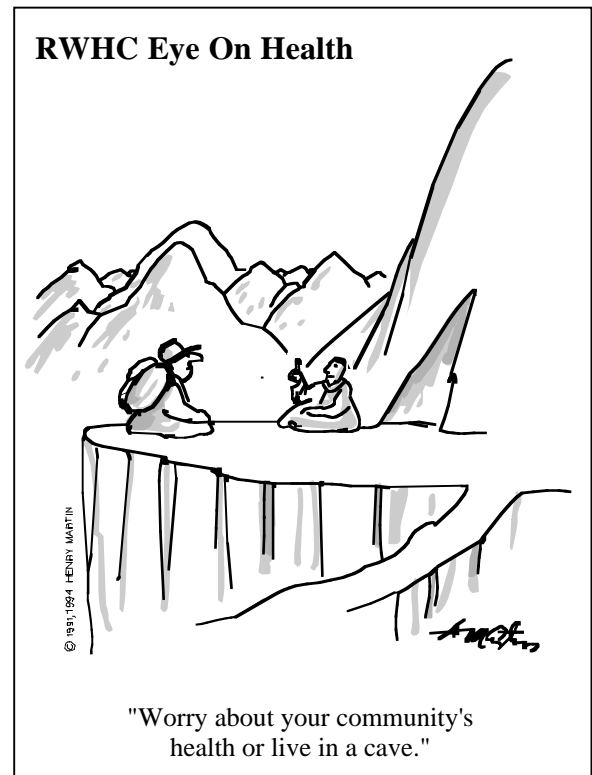
health. Because improvement in population health requires the attention and actions of multiple actors (legislators, managers, providers, and individuals), the field of population health needs to pay careful attention to the knowledge transfer and academic-practice partnerships that are required for positive change to occur. Figure 1 shows how we view the field of population health. The field investigates each of the components shown in the figure, but particularly their interactions.”

“Those in public health or health promotion may legitimately feel that population health is simply a re-naming of what has been their work or legacy. Hamilton and Bhatti have attempted to show the complementarity and overlap between population health and health promotion, building on the Canadian Achieving Health for All Framework for Health Promotion and the World Health Organization Ottawa Charter on Health Promotion. Frank has indicated that historic concepts of public health were similarly broad, until the biomedical paradigm became dominant. Those who define public health as the ‘health of the public’ would not disagree with the definition of population health proposed here; in the words of Frank, the ‘shift in thinking entailed in population health should be a small one for public health workers . . . in fact it is not so much a shift as a return to our historical roots encompassing all the primary determinants of health in human populations.’ ”

Uninsured Rates Affect All Of Us

From *A Shared Destiny Effects Of Uninsurance On Individuals, Families, And Communities* by the Institute Of Medicine, 3/03; the full text is available at <www.iom.edu/>. According to a private conversation with Institute Of Medicine staff, the term “uninsurance” in this article is intended to describe “the state of both individuals and groups (families, neighborhoods, or larger units) where there are uninsured persons”:

“There are adverse health and economic consequences for uninsured persons and their family members. Ripple or spillover effects of these consequences can spread to the community. For example, a



hospital outpatient department that sees rising numbers of uninsured patients without increased financial support may trim its hours or stop offering services that are costly to provide. This report establishes a framework for thinking about spillover effects on community access to care, the local economy, and the public’s health; assesses the limited evidence that exists; and proposes a research agenda to learn more about these effects. The community effects of uninsurance are often hard to see at a national level but can be quite vivid at the state and local level.”

“The national uninsured rate, 16.5 percent among persons under age 65, is an average that does not reflect the substantial variation among communities in uninsured rate, the length of time that residents are uninsured, or the relative concentration of uninsured persons in certain geographic areas. The size and characteristics of a community’s uninsured population matter because of the relationship between local coverage levels and the availability of health services.”

“Over the past twenty-five years, public policies to control health vary across the care costs and increasingly competitive health care markets have constrained payment rates. As a result, public support and private cross-subsidies for uncompensated care

have eroded. A community's particular safety-net arrangements and its effectiveness in caring for uninsured persons influence how uninsurance affects the community."

"These effects have been felt most strongly in communities with large or growing uninsured populations, particularly in central urban neighborhoods and in smaller rural areas, and in parts of the health care system such as public hospitals that serve many uninsured persons."

"Who Pays For Care For Uninsured Persons? We all do. Our taxes pay for services provided in public hospitals and clinics as well as for public insurance programs. Responsibility for paying for and providing health care to uninsured persons is fragmented and ill-defined. Although the mainstream health care system delivers most of the services that uninsured persons receive, the uninsured rely disproportionately on safety net providers and on public payment for their care."

"What Do We Know About The Effect Of Uninsurance On A Community's Access To Care? A community's high uninsured rate has adverse consequences for its health care institutions and providers. These consequences reduce access to clinic-based primary care, specialty health services, and hospital-based care, particularly emergency medical services and trauma care, and may also result in lessened availability of other primary and preventive care and the closure or privatization of community hospitals. The Committee thinks that uninsurance affects access through providers' responses to lower revenues. In aggregate, providers' revenues in areas with high uninsured rates are lower because uninsured persons on average use fewer services than do the insured and the care that uninsured persons do receive is typically not paid for in full by the uninsured."

"What Do We Know About The Effect Of Uninsurance On The Economic Health Of Communi-

RWHC 11th Annual Rural Health Essay Prize

Deadline Is April 15th—The Hermes Monato, Jr. Essay Prize is awarded annually for the best rural health paper. The writer of the winning essay will receive a check for \$1,000 paid from a trust fund established at the University by RWHC, family and friends of Hermes. It is open to all students of the University of Wisconsin. Students are encouraged to write on a rural health topic for a regular class and then to submit a copy to the Rural Wisconsin Health Cooperative as an entry by April 15th. All entries (no copies needed) must be submitted by April 15th c/o Monica Seiler, RWHC, P.O. Box 490, Sauk City, Wisconsin. Previous award winners and titles (and in some cases, a link to the paper) as well as judging criteria and submission information is available at:

www.rwhc.com/essay.prize.html

ties? State and local government capacity to finance health care for uninsured persons is weaker during time periods when the demand for such care is likely to be highest. Starting in 1999, states have experienced hard times with economic recession and reductions in federal Medicare and Medicaid payments along with public resistance to raising taxes."

"The unreimbursed costs of caring for uninsured Americans are ultimately paid for by higher taxes and higher prices for services and insurance. Local communities tend to bear the main economic burden of subsidizing service delivery, while the costs of public insurance are more broadly spread across state and federal budgets. Federal support can alleviate some of the financial demands that uninsurance places on communities."

"Responses of government to these pressures, together with associated economic consequences, are likely to include the following:

- Public subsidy of care delivered to uninsured persons, requiring that additional public revenues be raised through higher local taxes, new federal dollars, or budget cuts elsewhere. During economic downturns, when there is an increased demand by more uninsured persons for services, budget cuts that decrease state and local public spending on health care may reduce the flow of federal dollars (such as Medicaid matching funds) into a community.
- Increases in the local costs of health care and health insurance resulting from providers' attempts to spread their unreimbursed costs across all patients. When health insurance costs go up, employers find insurance less affordable to offer and fewer employees purchase it.
- The closure of local health services institutions and medical practices because they have been in-

adequately reimbursed, particularly in rural areas. This can weaken the community's economic base and reduce local availability of health care."

"In *A Shared Destiny*, the Committee finds that the adverse effects of uninsurance have spillover effects on the community. The Committee believes it both mistaken and dangerous to assume that the persistence of a sizable uninsured population harms only those who are uninsured."

Antismoking Measures —The Perfect Storm

From 'Antismoking Measures Gain in Tobacco Country' by David Halbfinger in *The New York Times*, 3/04/03:

"Governors, lawmakers and even chambers of commerce are calling for increases in cigarette taxes, not only to close gaping state budget deficits, but also to help prevent smoking. In state capitols and county courthouses, bans on smoking that were unthinkable a year or two ago are being enacted every few days."

"In short, a seismic political shift that was a decade in the making is toppling old alliances and redrawing the landscape of tobacco country. Besieged growers, their yearly quotas cut by half or more, have switched allegiances and are shunning the cigarette manufacturers who now buy as much or more tobacco from foreign farmers. Instead, the growers are turning for aid to the very antismoking advocates they once saw as mortal enemies."

"Now, public health groups like the Campaign for Tobacco-Free Kids are lobbying Congress for a \$16 billion buyout for tobacco farmers in exchange for the farmers' support of the regulation of cigarettes by the Food and Drug Administration. As a result, efforts at local and state levels to curb smoking are encountering less and less resistance."

" 'I've been in these wars since 1990,' said Anthony J. DeLucia, a professor at East Tennessee State University who is the chairman of the American Lung Association. 'It used to be the health groups would parade up somebody with emphysema or cancer, and the tobacco industry would have the farmer. We'd use these human shields in our arguments, as symbols. But the tobacco industry can't jerk the chain on the tobacco farmers like they used to, because the farmers have realized that the industry would love to just move everything overseas, where they can pay a next-to-nothing wage and spray any pesticide they want.' "

"For their part, farmers say they see little point in putting up much of a fight anymore and are more interested in winning a federal buyout that will let growers leave the business with at least their dignity intact. 'Once you stand in front of a tractor-trailer truck and get run over two or three times, it gets more difficult to stand in front of it again,' said Jimmy Hill, a grower in Kinston, N.C."

"With farmers largely sitting out the debate, antismoking legislation is sweeping the Southeast."

NRHA 26th Annual Conference,

"The Changing Rural Landscape"

May 13-16

Grand American Hotel, Salt Lake City.

Register at www.NRHArural.org

"A decade ago, farmers and the public health groups were bitter enemies. The Depression-era program of quotas for tobacco production was constantly under attack in Congress, and the antismoking lobby, led by the American Heart Association, the American Lung Association and the American Cancer Society, supported its abolition. But

beginning in Virginia in 1994 and in Kentucky in 1995, farmers and officials of the health groups met in halting, initially contentious talks that did much to clear up misconceptions on both sides."

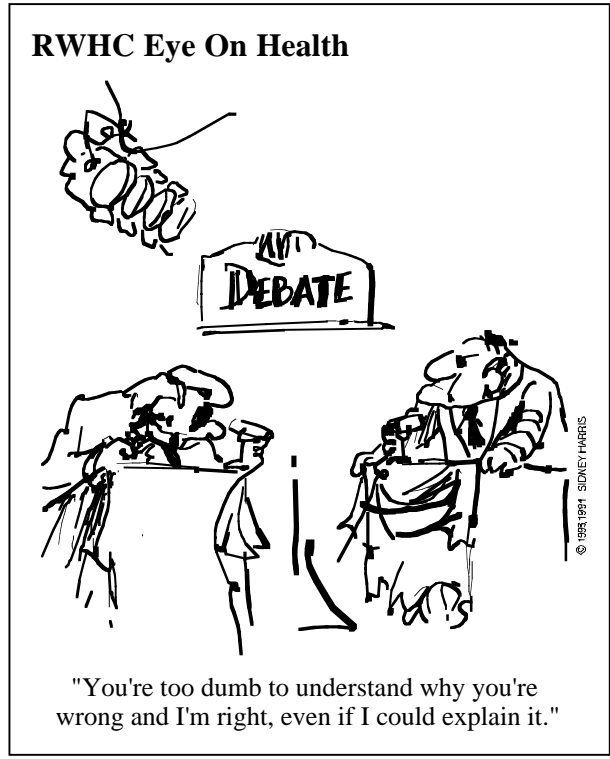
" 'We became educated,' said Amy Barkley, then a local tobacco control advocate in Kentucky and now a coordinator for the Campaign for Tobacco-Free Kids in five tobacco-producing states, 'the belly of the beast,' as she calls it."

" 'We learned that getting rid of the tobacco program didn't stop one cigarette from being smoked, it just

opened it up to lower prices, which could mean the opposite,' Ms. Barkley said. 'We were sold on the health benefit of quotas and price supports. So we dropped our opposition to the program and then began defending it.' ”

“What began in secret in the mid-1990’s has now come nearly to fruition as tobacco growers are pushing for a federal buyout worth \$15 billion to \$20 billion, and their strongest backing is coming from public health groups.”

“For a grower with 100 acres in flue-cured tobacco country, the buyout could mean a payment of \$800,000; the owner of that much quota would get \$1.6 million. Mr. Hill said the payments would allow farmers to ‘get out of tobacco with some dignity.’ ”



“At a hearing in Frankfort on Feb. 4, even the dean of the University of Kentucky’s medical school, Dr. Emery A. Wilson, spoke for a tax increase after 15 years of silence on tobacco control efforts. His voice breaking, Dr. Wilson said he had held his tongue until then out of fear of political retaliation from farmers and their representatives in the Legislature.”

“ ‘At some point, we need to do more what is right than what is politically expedient,’ he said. ‘None of us will win the Nobel Prize, become president or do anything of real lasting significance in the world. Most likely what we do will be through our children. And one of the best things we could do would be to protect their health.’ ”

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