

Review & Commentary on Health Policy Issues for a Rural Perspective – August 1st, 2004

## Healthcare—The ‘Calm’ Before the Storm

The following is by Tim Size, also published as a guest column in the 7/22 edition of *Agri-Review*:

“American healthcare is by no means calm; it is facing many challenges, both old and relatively new. The amount of change faced today by patients, providers and purchasers is greater than anything I have seen in my 30 plus years in ‘the business.’ The accumulating weight of unresolved challenges is leading many people to say that our current healthcare and insurance system will not be able to continue as it now is.”

“Farmers and rural healthcare providers have a lot in common when they face ‘stormy weather.’ Predictions of storms are uncertain; the real work is in the preparation and in the cleanup; storms can bring needed change or major destruction. I don’t know farming but I do know healthcare and I believe we need to prepare for the storm of the century.”

“Storm clouds include: The cost of care and of insurance continues to rise significantly faster than general inflation and wages. Employers are shifting to employees more of the cost and financial risks of health care. Our economy is becoming global, competing against countries with much lower healthcare costs.

“The people that get on in this world are the people that get up and look for the circumstances that they want; and if they can’t find them, they make them.” George Bernard Shaw  
RWHC *Eye On Health*, 7/16/04

Federal and many State budget deficits will limit public dollars available for healthcare. ‘Baby boomers,’ the pig in the demographic python, are entering an age when their need for care starts to increase dramatically. At the same time, a large share of skilled health workers will be retiring and not easily replaced. We continue to invent drugs that help a little but cost a lot more. We expect more convenient care of higher quality. And we all expect to live longer and better.”

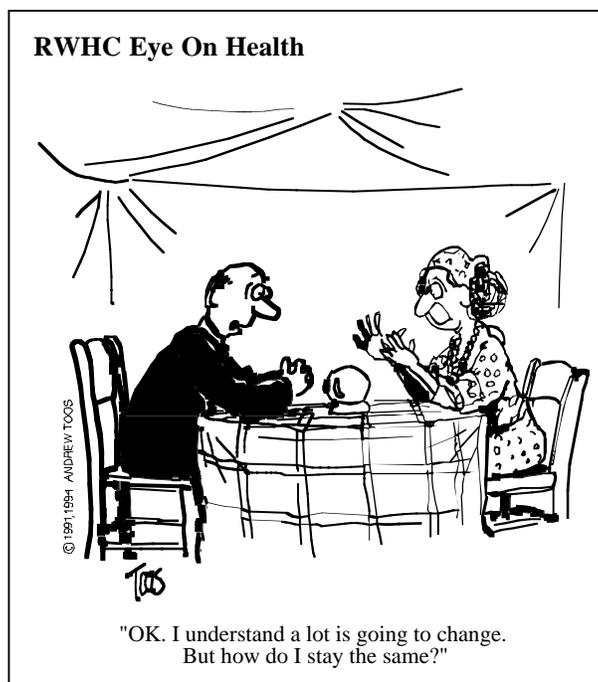
“These trends will affect healthcare for all of us but there are a couple of issues that are particularly relevant to farmers, their families and communities.”

### Farmers Have Second Class Access to Health Insurance.

“A farmer’s health insurance is often not for healthcare. ‘Health’ insurance with very high deductibles protects the

farm against catastrophic healthcare bills but tends to discourage farmers from seeking the care they need when they need it. The number of farmers without health insurance, or with health insurance they can’t afford to use, is increasing. As the failing health insurance system becomes a personal issue for more people, the political consequences of inaction are growing.”

“Health coverage varies by industry and occupation. ‘Uninsured rates by industry run as high as 33% in agriculture and construction to just 6% in public ad-



ministration. The gap in coverage is over two-fold between white- and blue-collar workers, 9% vs. 23% uninsured respectively,' according to the Kaiser Commission's 2003 Report on 'Medicaid and the Uninsured' It's a bad joke that the people, who work in agriculture, the people most frequently brought out by both political parties as a symbol of traditional Americans, have the highest rate of being uninsured."

"There are 'reasons' why farmers, like other small businesses, continue to pay significantly more for their health insurance: (1) farming is high risk work, (2) farmers typically can only buy individual policies without the economic leverage of group purchasing, (3) farmers who need more health care are more likely to buy insurance, making it a more costly risk pool for insurers. We know this, but less talk and more action are needed to change these 'reasons' into a bad memory."

"The Wisconsin Federation of Cooperative's tireless work in support of establishing 'Co-op Care' deserves recognition. As noted by Melissa Duffy in the July 5<sup>th</sup> edition of *Agri-Review*, 'Co-op Care will primarily focus on rural Wisconsin and will provide bargaining power to farmers and rural small businesses that have had little or no bargaining power in negotiating for affordable, quality healthcare. The cooperatives will bring together those who have purchased health insurance on a self-employed basis into a group. The cooperatives will then contract with existing insurers to provide health insurance coverage at group, rather than individual, rates.' "

"The Federal Government needs to provide the requested start up funds for Co-op Care and similar collaborative projects if farmers are ever to have access to the level of health insurance taken for granted by most Americans."

**Medicare Drives Rural Health.** "The public debate about last year's Medicare Modernization Act focused on prescription drugs for seniors. The new law also lays the groundwork for total reform of the Medicare System. But for rural hospitals, the focus was on the fact that it brought more assistance than we have seen in the last 20 years. This is critical to rural communities because Medicare typically represents 55% to 70% of a rural hospital's revenues. As goes Medicare, so goes the rural hospital. Compared

to what Medicare spends on the average beneficiary, the upper-Midwest has been very disadvantaged. Wisconsin's 'shortfall' has been about a billion dollars per year. Historic payment formula inequities for rural hospitals and physicians have accounted for a significant part of that difference. This law reduces that gap."

"Higher Medicare payments mean more local services for young and old alike. It means less pressure on private payers to make up for federal shortfalls. The Medicare Modernization Act does not resolve all rural issues with Medicare, but the additional support puts rural healthcare providers and their communities in a much better position to prepare for the future."

"Unfortunately, every act of Congress is also subject to the 'law' of unintended consequences. The Medicare Modernization Act is no exception. Its creation of the Medicare Advantage program constitutes a potentially serious threat to rural healthcare. Medicare Advantage is intended to be an alternative to traditional Medicare. It is intended to address projections that the rate of current spending will exhaust the Medicare Trust Fund in 20 years. To do so, Medicare will make much greater use of HMOs and other private health insurance plans."

"In this context, rural advocates are calling for legislation that would assure that as Medicare is redesigned, it continues to protect the rural infrastructure. We need to assure that rural hospitals and clinics are

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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paid fairly, whether they serve a traditional Medicare patient or a Medicare Advantage patient. This action is necessary for essential rural providers if they are to survive in the competitive world of Medicare Advantage envisioned for urban and rural markets.”

**Insurers May Undermine Local Care.** “Rural providers need to be careful about winning fairer reimbursement on one hand while losing patients to urban centers on the other. It is absolutely critical that Medicare Advantage and commercial health insurers not force beneficiaries to leave the local community for care. Federal and many state laws require health insurance companies to respect ‘local community patterns of care.’ But enforcement is uneven.”

“For most people in rural communities, ‘local community’ means ‘local community.’ It does not mean being forced to travel throughout the region, state or Midwest. Clearly if a local community has and uses a local hospital and physicians, Medicare Advantage plans and commercial insurance companies should respect that pattern and offer to contract with local providers on terms comparable to what they pay elsewhere.”

“A practice appears to have grown up in the managed care universe by which actual travel times within a community can be ignored as long as some arbitrary notion of reasonableness is followed. But reasonableness according to health plans isn’t the standard; the standard is supporting ‘local community patterns of care.’ If a significant portion of a rural community is not allowed to use local physicians or the hospital, that resource for both emergency and regular care can easily be lost. This is a critical public policy issue still to be resolved.”

**Healthy Communities Spend Less.** “Reasonably priced health insurance is only half of the challenge; the other half is to aggressively work to reduce our need for health care in the first place. There is a growing awareness among purchasers of health insurance and healthcare as well as providers that we need to ‘go upstream’ to reduce the need for and cost of healthcare services. Yes, the quality and cost of healthcare significantly effects an individual’s health but behaviors (smoking, alcohol/drug use, physical inactivity, overweight, motor vehicle crashes, etc.) and social economic factors (education, poverty, divorce rates) are much stronger predictors of how

healthy a community is and how much it needs to spend on medical care.”

“An example from Wisconsin: Dr. Charles McCauley, M.D., a cardiologist and others in the local community have started the Marshfield Clinic Healthy Lifestyles Initiative. The Initiative is part of a coalition of community members who want to foster change in the culture of the community to improve the health of its people. Community members include representatives from Marshfield’s public schools, the city, and businesses. ‘It has become a circle,’ Dr. McCauley said. ‘We wanted to reach children in school, but schools only have them a few hours a day. So we needed to change the community, make it more pedestrian friendly and improve parks and trails for more community physical activity. And we wanted to reach parents with the same message their kids are getting at school, a message about making good food choices and getting enough exercise.’ ”

“This along with many other similar initiatives is just beginning to take hold in mainstream healthcare thinking. America’s top medical authority, the Institute of Medicine, says that initiatives like that in Marshfield needs to be the norm, not the exception. ‘The health care system of the 21<sup>st</sup> century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal health care with broader community-wide initiatives that target the entire population. The health care system must have well-defined processes for making the best use of limited resources.’ The challenge is that today, a very small part of our country’s healthcare spending is invested in such community-wide initiatives. That must change as we cannot afford for it not to.”

**Strong Rural Health Requires Speaking Up.** “The myths about rural healthcare, like farming, aren’t generally intended to cause harm but they can do so nonetheless. Just a few examples: ‘Rural health care should be cheap’ (It was once seriously suggested to me by a state healthcare leader that rural hospitals should be cheaper because they could grow their own food.) ‘Rural residents don’t care about local care as they can get all of their needs met in regional centers.’ ‘Urban is better.’ ”

“Rural America is an important part of our country’s landscape and self-image, past and present. Rural health frequently gains support across the political spectrum (an increasingly rare phenomena in our unfortunate era of rabid partisanship). But we must face the reality that much of our private corporate and government sector policy is developed in urban centers based on generalizations about the country as a whole by people with little direct experience with rural communities and enterprises.”

“Rural health clearly faces stormy weather. The signs are everywhere but when and how it will arrive is uncertain. Whether it will bring the renewal of soaking rains or the destruction of a tornado is unknown. What we do know is that this is a time of preparation. As rural advocates, we have our work cut out for us. We must develop the best and most cost effective care we currently can while speaking out loudly and clearly in our state and national forums on behalf of the future of rural health.”

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## Healthcare Transformation & Odd Bedfellows

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From ‘Vision of Newt’ by Ceci Connolly in *The Washington Post*, 7/13/04:

“Like any good visionary, Newt Gingrich has a vision—or two, or three. Take his vision for the health system of the future. Each morning millions of Americans would awaken and log on to a secure, personal Web page featuring their individual medical record. It would track health status—weight, height, blood pressure, maladies and medications—and deliver reminders and advice where appropriate for managing their diseases and conditions.”

“When they needed care, patients would shop online, comparing prices and quality scores of the doctors and hospitals in the region. They could research the efficacy and risk of various treatments. At the doctor’s office, the physician could look up the latest innovations with a tap on a wireless, palm-sized computer and use the same device to write prescriptions or order tests, all of which would automatically be recorded in the patient’s electronic file. And if a small-town doctor didn’t have the expertise for a

certain diagnosis or procedure, she could link via satellite with experts halfway around the globe.”

“Reforming the system will not do, according to Gingrich. It must be *transformed*. ‘There is no middle ground,’ he declared. ‘Without transformation, we can’t compete and we become western Europe: gracefully decaying, living pretty well, being pretty interesting, but in fact no longer in the game.’ ”

“The quest to rescue America from that dismal fate is Gingrich’s new mission, a project that began with a book and has grown into a new think tank focused on promoting technology, individualism and free market principles in the medical arena.”

“At a time when people buy gas without meeting an attendant, extract cash from an ATM in a foreign country and read headlines on cell phones, Gingrich is appalled that prescriptions are still written by hand, X-ray results are delivered via the postal service and patients have to pay money for photocopies of their own paper medical files. ‘This is not science fiction; this is banking 30 years ago,’ he added. ‘All we’re trying to do is catch up.’ ”

“It is natural that Gingrich would gravitate to the \$1.6 trillion industry—and take on the entire system, said aide Nancy Desmond. In her 12 years with Gingrich, Desmond has watched her boss find the areas in which he can have the greatest impact. As she put it: ‘One of his philosophies is moving to the sound of the guns.’ ”

“Part of Gingrich’s effectiveness derives from his ability to take complex ideas and relate them to everyday experiences. On health care, he says, think Wal-Mart prices at Travelocity speed. Simply put, Gingrich believes that individual Americans armed with the latest gadgetry and information make the best health care consumers—and when they take responsibility for their own care, prevention will improve, prices will plummet and quality will soar.”

“The approach is appealing, Gingrich argued, because it focuses on health first and financial savings second. ‘If I can get somebody to never become a diabetic, they don’t mind that we’re not paying for insulin,’ he told the business crowd in Atlanta. ‘If they become diabetic but I get them to manage the diabetes so they don’t need kidney dialysis, they

don't mind that we don't pay for the dialysis.' 'On the other hand, if they think I'm going to save money by having them die early by not paying for something, they get really angry.' "

"Across the political and medical worlds, there is widespread agreement on the large themes articulated by Gingrich. For years, decision-makers have embraced in theory the need for modernizing medicine. And most agree that if and when the U.S. system does so, quality will improve and money will be saved."

"But beyond that, academics, physicians, corporate leaders and politicians diverge sharply on how to get there, what government's role ought to be, how to sell radical change to physicians and whether patients will make the wisest medical decisions, particularly in a health crisis."

"It is both a testament to his political skill and the salience of the issue that Gingrich is playing policy footsie with the likes of Rep. Kennedy, Sen. Hillary Rodham Clinton (D-N.Y.) and William Novelli, executive director of AARP. Of all the curious alliances Gingrich has built since leaving office, none is more striking than the intellectual courtship taking place between him and Clinton."

"It started with a magazine article in which she praised his book and ideas on information technology. The 'personal health record' she described is nearly identical to the vision Gingrich sketches. The man who helped lead the impeachment fight against Clinton's husband now cites their agreement as evidence of the rightness of his ideas. On that, she agreed."

" 'I've learned through many years in Washington when an idea comes to maturity you will have people from different places on the political spectrum coming together to advocate for it,' Clinton said in an interview. 'The more we can use technology as quickly as possible, the better we can manage disease and lower costs.' "

"Clinton just as quickly cites

areas of disagreement with the former speaker. She strongly rejects Gingrich's promotion of health savings accounts or tax credits for consumers to buy their own health insurance. She also disagreed with the notion that patients are always best positioned to shop for care."

" 'I don't believe you can empower individuals lying on the side of the road from a motorcycle accident so they can make the best choice of what trauma center to go to,' she said."

"Still, aides to both see enormous political upside to any partnership. For Clinton, Gingrich could help erase the scars of the 1994 health care debacle, when as first lady she was vilified for promoting a massive overhaul of the entire health care system. For Gingrich, now out of office, Clinton represents an opportunity to translate his ideas into legislation."

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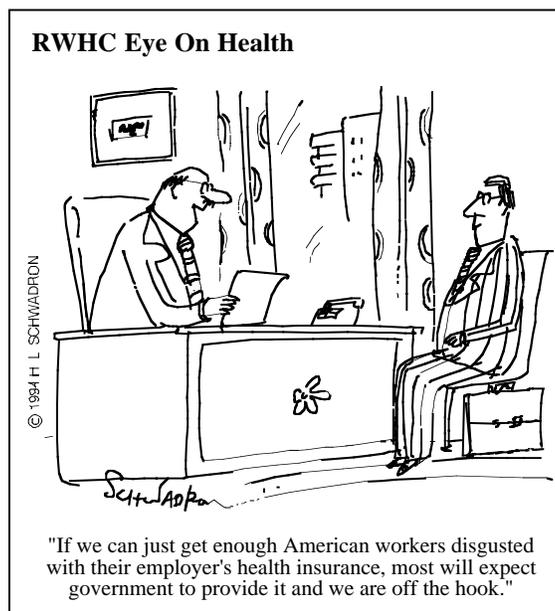
## Health Insurance Market Doing Self In?

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From the news release "Workers Worry About Losing Job Health Coverage; Express Growing Enthusiasm for Government Plan" by the Employee Benefit Research Institute, 9/29/03:

"A declining percentage of American workers are confident that their employers will continue offering health insurance in the years ahead and a growing group thinks a system of government coverage would work better, according to the sixth annual Health Confidence Survey released today by the Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc."

"Between 2000 and 2003, the percentage of Americans with employment-based health benefits who are extremely or very confident that their employer will continue to offer coverage has declined from 68 percent to 61 percent. In the past year



alone, the proportion of those with employer coverage who express a preference for a government-operated system jumped from 17 percent to 31 percent. But a majority of those in employment-based plans, 55 percent, continues to believe that the employment-based system is best. Among all Americans, support for a government plan jumped from 25 to 36 percent in the past year.”

“The 2003 Health Confidence Survey finds that Americans generally remain satisfied with the medical care they are receiving, but are increasingly uncomfortable about rising costs. In 2003, 48 percent said they were dissatisfied with health costs not covered by insurance, up from 37 percent in 1998. A comparable group, 44 percent, were unhappy about the cost of health insurance, up from 32 percent in 1998.”

“These cost concerns may explain why many Americans say health care is the most critical issue facing the nation today (20 percent say it is the top priority). Health care is second only to the economy (which 27 percent rate as priority one), and is on par with terrorism and national security (the main concern of 17 percent).”

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## Giving Rural Kids Something to Smile About

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From “Giving Rural America Something to Smile About” by Thomas D. Rowley, a Fellow at the Rural Policy Research Institute, 6/28/04:

“A meeting of dental experts, my four-year-old’s first trip to ‘the funny-looking chair where they look in your mouth’ and an aching molar have me thinking a fair bit these days about teeth. Make that ‘oral health,’ an odd sounding but important and underrated concept.”

“Broadly defined as freedom from any number of diseases and conditions affecting the mouth and all its parts, oral health (and health care) have long played second fiddle to other aspects of health and health care, despite links between oral health and diabetes, osteoporosis, heart and lung conditions, and certain adverse pregnancy outcomes.”

“As the Department of Health and Human Service’s report, *A National Call to Action to Promote Oral Health*, put it, ‘the perception that oral health is in some way less important than and separate from general health has been deeply ingrained in American consciousness.’ ”

“Not surprisingly then, the nation scores poorly on its oral health report card. A 2000 report by the Surgeon General, *Oral Health in America*, said a ‘silent epidemic of oral diseases is affecting our most vulnerable citizens’ poor children, the elderly, and many members of racial and ethnic minority groups.’ Add to that list, rural Americans.”

“Even after controlling for population density and income, the most rural counties have fewer than half the number of dentists-per-100,000 population (29) than large metropolitan areas (62). Consequently, three-quarters of the nation’s Dental Health Professional Shortage Areas are rural.”

“Rural adults aged 18 to 64 are nearly twice as likely than their urban counterparts to have lost all their teeth. Those that haven’t lost their teeth are much more likely to have untreated dental decay.”

“Finally, rural residents are less likely than urban residents to have dental insurance. Forty-one percent of rural children lack dental insurance compared to 34.7 percent of urban kids.”

“According to the National Advisory Committee on Rural Health and Human Services, several factors are to blame: geographic isolation, lack of adequate transportation, lack of fluoridated community water supplies, higher rates of poverty, larger percentages of elderly, and public and private insurance programs that pay less for services provided in rural areas than those provided in urban—even when the treatment costs the same or more. So, what can be done?”

“Conversations among experts at a gathering hosted by the National Rural Health Association and the Federal Office of Rural Health policy ginned up several good ideas. They are, however, only ideas I heard, not policy recommendations by either group.”

***“Communicate the importance of oral health to overall health and well-being.*** We now know that

oral health is critical to overall health, self-esteem, and even employability. That message needs to be heard loud and clear.”

“*Get more oral health providers into rural America.* Easier said than done. Still, several approaches are worth considering.”

“Raise Medicaid reimbursement rates for oral health services in rural areas to make it more attractive for dentists to treat Medicaid patients (of which there are many in rural areas).”

“Expand the use of dental hygienists, assistants, and other allied health providers, so that it doesn’t take a dentist to do everything.”

“Require dental students to complete a residency and provide incentives for them to do it in rural underserved areas. Doing so would add some 3,000 caregivers each year and increase the number of folks getting treatment by several million.”

“Allow foreign-trained dental students who complete their residency here in underserved areas to get a U.S. license.”

“Increase the use of incentives such as loan repayments in exchange for rural service.”

“These are just a few ideas I heard. The list goes on and on. Some will work; others will not. The point is that improving rural Americans, access to high quality, affordable oral health care is important and it won’t be achieved over night. It will take smart, hard work. Most of all, it will take political will from policymakers, faculty and administrators in oral health programs, and oral health providers themselves. It can be done, but we’d better get started.”

Other Rowley columns are at: [www.rupri.org/editorial](http://www.rupri.org/editorial)

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## Rural Do & Can Meet Quality Standards

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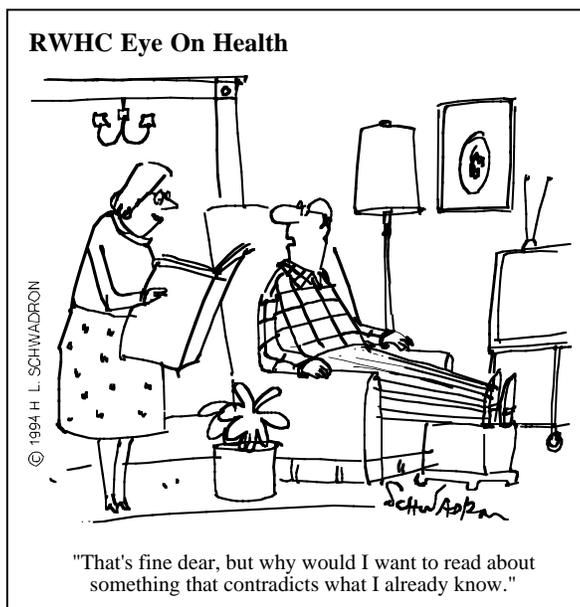
CheckPoint is a comprehensive source for consumers and employers in Wisconsin intended to “provide reliable, valid measures of health care in Wisconsin to facilitate the selection of quality health care and aid in quality improvement activities within the hospital field.” A total of 122 hospitals, representing 99% of Wisconsin hospital admissions, participate in CheckPoint. According to CheckPoint’s sponsor, the Wisconsin Hospital Association (WHA), CheckPoint serves three purposes:

- “Provide purchasers with information on the quality of care provided by hospitals
- Provide consumers with information to facilitate their choice of provider
- Provide hospitals with information for quality improvement”

According to WHA, “CheckPoint currently provides consumers and employers with reliable, valid data on 5 error prevention goals and 10 key clinical interventions that medical experts agree should be taken to treat heart attacks, heart failure and pneumonia, the three most common causes of hospitalization in Wisconsin. The web site, [www.wicheckpoint.org](http://www.wicheckpoint.org), tells consumers how often hospitals delivered care that is scientifically shown to improve outcomes.”

The clinical intervention data was updated for the first time on June 15 after the sites initial launch on March 30. In September, the safety data will be refreshed as well as the first cohort of new measures will be added.

A very welcome finding of CheckPoint subsequent to the most recent data update is that among hospitals with enough cases accumulated to be representative of care provided and reported, **rural hospitals in**



**aggregate performed better or comparable to the statewide averages for 4 of the 5 error prevention goals and 7 of the 10 initial key clinical interventions.**

This finding is supportive of the quality care rural hospitals can and do provide and the ability of smaller institutions to gear up more quickly to new initiatives. While it is to be expected that these comparisons will change over time as more hospitals report and as new measures are identified, it is a good beginning.

But we should expect that hospital boards of directors and the purchasing community would expect all hospitals to improve performance, particularly where there is a substantial gap with state and national benchmarks. In other words, being better than average isn't good enough if the average falls short.

There are collaborative opportunities through RWHC to facilitate the improvement of outcomes measured by CheckPoint. While the relative rural performance is good, there are two indicators where hospitals (rural and urban) show up as significantly lower than the

benchmarks: Mean Time to First Antibiotic Dose (“Average time from arrival at the hospital to administration of the first dose of antibiotic for patients admitted to the hospital with pneumonia.”) and Pneumococcal Screening and/or Vaccination (“Percent of patients 65 years and older admitted to the hospital with pneumonia that are asked if they had received a pneumococcal vaccination, and if they had not, received the vaccination prior to discharge from the hospital.”)

The RWHC Board has asked Cooperative staff to work with the RWHC Quality Roundtable to develop specific recommendations regarding the “best practices” for member hospitals to improve the CheckPoint scores for “Mean Time to First Antibiotic Dose,” “Pneumococcal Screening and/or Vaccination” as well as other CheckPoint Measures the Roundtable may choose to address.

**Annual NRHA Critical Access Hospital Conference**  
Oct 6 - 8, 2004 at the Westin Crown Center Hotel  
Kansas City, MO  
[www.nrharural.org/pagefile/NRHAconf.htm](http://www.nrharural.org/pagefile/NRHAconf.htm)

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