

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

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## Wisconsin Academy for Rural Medicine

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*RWHC has received a planning grant from the Wisconsin Partnership Fund for a Healthy Future. The application was developed in partnership with the University of Wisconsin Medical School, Southwest and Northern Area Health Education Centers and St. Clare Hospital & Health Services in Baraboo:*

**Title of Proposal:** “*Wisconsin Academy for Rural Medicine (WARM)*—The development of a community-academic collaboration to improve access to physicians in Wisconsin’s rural communities.”

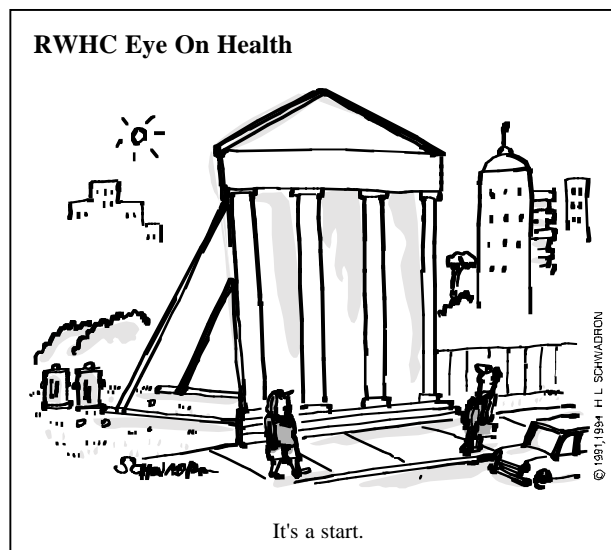
**Project Outcome:** “Improved access to essential physician services in rural Wisconsin communities.”

**Statement of Need:** “The presence of qualified health professionals is an important influence on access and quality of rural health care. Physician maldistribution, by practice location and specialty, continues to hinder access to quality medical care and there is broad agreement that rural regions are among the most disadvantaged. The shortage of physicians in Wisconsin’s rural communities is a longstanding problem, and state policymakers and educators need to address the challenge of finding effective methods to increase the supply of rural physicians.”

**Project Goal:** “Increase the number of University of Wisconsin Medical School graduates who practice in rural Wisconsin communities.”

### Project Objectives:

- I. “By October 1, 2004, the initial planning team will organize and facilitate a *Wisconsin Rural Medical Education Advisory Committee (WRMEAC)* with expanded participation.”
- II. “By February 28, 2004, WRMEAC will develop strategies and recommendations to increase the number of UWMS graduates who practice in Wisconsin’s rural communities through the development of the WARM program.”
- III. “By May 2005, WRMEAC will develop recommendations for determining long-term indicators to track, monitor and evaluate implementation of the proposed plan, and develop recommendations to promote residency education in rural settings.”



### The Challenge in Wisconsin

“In response to this challenge and the charge of the recent report by the Wisconsin Hospital Association and Wisconsin Medical Society, ‘*Who Will Care For Our Patients, Wisconsin Takes Action to Fight a Growing Physician Shortage,*’ this planning grant seeks to develop a comprehensive, coordinated and strategic approach to Wisconsin’s rural physician shortage problem through a collaborative process.”

“Inherent in this process is the understanding that people and groups of people working together to solve a problem and to create a shared vision is an effective strategy to implement positive change. The creation of a new model of rural medical education is not an easy task, but the process can be strengthened and reinforced when those who are most affected are involved in the planning, implementing and evaluation of that model.”

**The National Rural Recruitment and Retention Network (3R Net) Recruitment and Retention Conference is scheduled for October 7-8, 2004 in Madison, Wisconsin.** 3R Net encourages non-members to participate, make their needs known, share their recruitment and retention experiences and learn from 3R Net members and speakers. At this time they have representatives from 26 states registered. The subsidized \$100 registration fee includes breakfasts and lunches both days. A “How To Recruiting for Retention” workshop is available on Friday afternoon for an additional fee. More information is available from:

**Fred Moskol, Executive Director, 3R Net**  
608-233-9560 [fmoskol@wisc.edu](mailto:fmoskol@wisc.edu) <http://www.3rnet.org>

“Developing a successful partnership between the medical school and rural communities to develop the right educational program is an effective way to cross boundaries between academic and community entities. Such a partnership requires joint participation of all the affiliated partners including academic administrators, key faculty, health systems, hospitals, community-based organizations, and rural leaders who agree to explore and search for solutions together. All have a stake in the outcome, which is to secure a physician workforce that will meet the needs of Wisconsin’s rural communities.”

“To pursue a shared interest by the UW Medical School and rural leaders in improving physician supply in rural Wisconsin communities, this grant will support the development of a *Wisconsin Rural Medical Education Advisory Committee* (WRMEAC). WRMEAC will seek to bridge the gap between the urban academic environment and rural practice communities. WRMEAC’s primary responsibility will be

to develop a proposal for a ‘school within a school’ program, the *Wisconsin Academy for Rural Medicine* (WARM), aimed at rural physician training at the University of Wisconsin Medical School.”

“This comprehensive rural medical education program will combine a focused admissions process with an educational program designed to prepare students for rural practice and provide for extensive clinical training in rural Wisconsin settings. In addition, WRMEAC will also make recommendations for promoting residency education in rural communities throughout Wisconsin. The committee will also make recommendations for tracking, measuring, and advising on progress towards meeting the physician needs of rural communities now and in the future. WRMEAC would be in position to serve as an ongoing community advisory committee to the UW Medical School given its role and charge for this project.”

“In summary, the focus of this collaborative planning process is to develop strategies to:

- Improve primary care and other needed physicians in Wisconsin’s rural communities
- Improve primary care, population/community health, health promotion and disease prevention training relevant to rural citizens
- Target medical students with rural background and career goals
- Sustain and support rural-based training experiences through medical school education
- Promote residency education in rural communities”

**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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## Ad-Hoc Training of Docs Doesn't Do It

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From “A View from the Periphery — Health Care in Rural America” by Roger A. Rosenblatt, M.D., M.P.H., in the *New England Journal of Medicine*, 9/9/04:

“Americans tend to view the rural United States as a larder, a playground, or a place to retire. But although agriculture now employs less than 3 percent of the nation’s workforce, more than 50 million people—20 percent of our population—live in places defined as rural by the 2000 Census. Inhabitants of rural areas are generally older, poorer, and less likely to have health insurance than inhabitants of urban areas. Enormous regional variation masks the fact that rural America contains pockets of deep poverty; of the nation’s 500 poorest counties, 459 are in rural areas.”

“Rural America exists at the periphery of our society; it is defined in relation to its urban counterpart as comprising places with relatively low population density that are remote from urban centers. These areas must import most of the equipment and people needed to provide health care, from health care professionals to hospital architects.”

“One of the signature characteristics of the rural health care system is the relative shortage of health care professionals. The diffusion gradient for physicians is particularly steep: the smaller and more remote the place, the more difficult it is to attract and retain physicians.”

“Rural areas differ qualitatively from urban communities in terms of their reliance on generalists for medical care. Forty-one percent of the physicians practicing in small rural areas — towns of fewer than 10,000 people — are family physicians, and an addi-

tional 19 percent are general internists and pediatricians. The number of graduates of U.S. medical schools who are interested in primary care in general, and family medicine in particular, has decreased rapidly during the past eight years — a change that may lead to shortages of rural physicians as the current generalists begin to retire. Moreover, very few medical schools or residency programs are located in rural areas, exacerbating the recruitment challenges faced by these communities.”

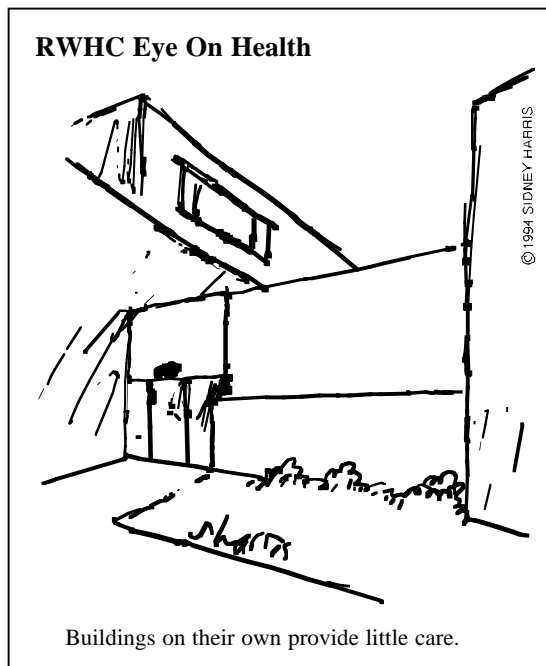
“Although the flow of physicians to rural areas can be increased by selecting students from rural backgrounds and training them in medical schools and residencies with tracks focused on rural health care,

few schools sponsor such programs. Despite federal and state efforts to bolster training, academic health centers value research-intensive, specialized models of care over primary care, and their main product is urban specialists. At the same time, the public school systems in many rural communities are weak, and the number of rural students admitted to medical schools has decreased by almost 50 percent over the past decade. Thus, shortages of physicians in rural areas may worsen.”

“Rural hospitals — a critical part of the health care system in most small communities — are a prod-

uct of federal policy. We owe the existence of most of our stock of aging rural hospitals to the federal Hill-Burton program initiated after the Second World War. Because most inpatients cared for in the country’s 2200 rural hospitals are Medicare beneficiaries, the fiscal well-being of these hospitals has oscillated with changes in Medicare reimbursement. When Medicare ratcheted down reimbursements in the late 1990s, many rural hospitals approached bankruptcy.”

“Largely because of political pressure to rescue these hospitals, Congress created the Medicare Rural Hospital Flexibility Program in 1997, establishing a new kind of rural inpatient facility — the Critical Access Hospital. These facilities are exempt from the strictures of Medicare’s prospective payment system and



receive ‘reasonable-cost’ reimbursement for services. The creation of this category provided a fragile safety net for small rural hospitals, the majority of which will have been certified as Critical Access Hospitals by 2005.”

“Since the 1970s, the federal government and individual states have been actively trying to improve rural health care delivery, and today the majority of the nation’s approximately 1000 Community and Migrant Health Centers — local nonprofit, community-owned providers — are in rural areas, providing care for an increasing proportion of rural residents. The establishment of the Office of Rural Health Policy in 1987 signaled a congressional desire to create a focus for developing rural health policies within the federal government and for effectively catalyzing policy-oriented research. The sheer number of programs reflects the political reality that most states have a substantial rural population whose elected representatives vigorously represent their interests. The most effective interventions are those that support the education of primary care clinicians, increase the flow of providers to rural areas, strengthen and support rural health care institutions, and integrate rural health care into larger regional systems.”

“Although they may live at the geographic periphery, rural patients increasingly demand access to the same spectrum and quality of care as their urban counterparts. Improving the quality of rural health care requires the integration of providers and institutions into larger systems, through the creation of networks and the use of electronic health records and telemedicine. Many complex services cannot be supplied safely or at a reasonable cost in rural communities. Effective rural systems must be based on a menu of core services, delivered largely by generalists in stable hospital and outpatient settings that are linked to regional centers.”

“Ensuring stability is a challenge. Because of the small size of many rural delivery systems, the loss of a hospital or a provider can undermine an entire local system. Congress has temporarily created an island of fiscal equilibrium for smaller rural hospitals through the Critical Access Hospital program. No such national policy has emerged with regard to the health care workforce. Because medical and nursing programs are dominated by academic health centers with

relatively little experience or interest in rural medicine, training has not met national needs. If we are to maintain high-quality patient care in rural communities, we need to develop mechanisms to attract and retain clinicians who are willing to practice in rural settings. Rural health care systems—because of their size and geography—will always be somewhat fragile. But a concerted national policy to sustain strong rural health care institutions—and the personnel to staff them—can ensure that access to and quality of care do not lag behind those in urban areas.”

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## Emerging Bipartisan View Healthcare is Sick

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From an editorial “How to Heal Health Care” by U.S. Senators Bill Frist and Hillary Clinton, 8/25/04:

“At a time when much of our public discussion is riddled with disagreement, there is an emerging bipartisan consensus in one vitally important area: that the challenges facing U.S. health care require major, transformative change. Some steps are already underway. Recently the Department of Health and Human Services announced a 10-year plan to build a new health information infrastructure. And while there is no consensus yet on all the changes needed, we both agree that in a new system, innovations stimulated by information technology will improve care, lower costs, improve quality and empower consumers.”

“Today our care is often afflicted by systemic error and dramatic inefficiencies. According to a recent Rand Corp. study, even patients with the best available coverage receive recommended care, on average, only 55 percent of the time. Costs continue to escalate far in excess of inflation. Health care providers are paid for episodes of care when a patient is sick or injured, rather than for ensuring that patients are healthy. In other words, patients pay to be covered by a plan or seen by a doctor, not necessarily to receive effective, high-quality treatment. Care is too often oriented toward acute, episodic illnesses of the past—not the chronic diseases that plague us now. Competition occurs among plans, networks and payers. It often does not sort out the best preventive, diagnostic and treatment strategies.”

“Moreover, our current health care sector suffers from profound technological inconsistencies. We lead the world in medical breakthroughs using some of the most advanced technologies ever developed. But at the same time, doctors and nurses struggle under mounds of paperwork, providers lose time trying to manage data and the latest research takes years to reach medical practices. By using advances in information technology, we can put the right information in the hands of doctors and patients at the right time. We can empower patients, health care providers and health care purchasers to make better choices.”

“Businesses in other sectors have embraced the information revolution to cut costs and improve productivity. They use information technologies not as an end but as a means to improve and innovate. It’s time we realize the full potential of the information revolution to improve the quality of the health care system as well.”

“The success of U.S. health care depends on patients’ taking charge of their care and becoming active participants in it. Information and access to it will be paramount. Consumers and patients do not have enough information to make good choices. They need information, including access to their own health records, and tools to make better choices, manage their care more effectively and communicate more efficiently with their health care providers. At the same time, we must ensure the privacy of these systems will undermine the trust they are designed to create.”

“We must also cultivate competition: Consumers need to know which doctors or care settings heal patients faster and better. Consumers need relevant information about providers’ experiences and outcomes.”

“We need to create standards of quality measurement so consumers can shop for good health care. More than a decade ago, the state of New York launched a revolutionary program of public reporting on heart

bypass surgery. Last year the New York Chamber of Commerce built on this effort by sponsoring the first statewide hospital report card.”

“Finally, consumers need information about the price of care. They must be able to compare health care pricing—with information that is readily, publicly available.”

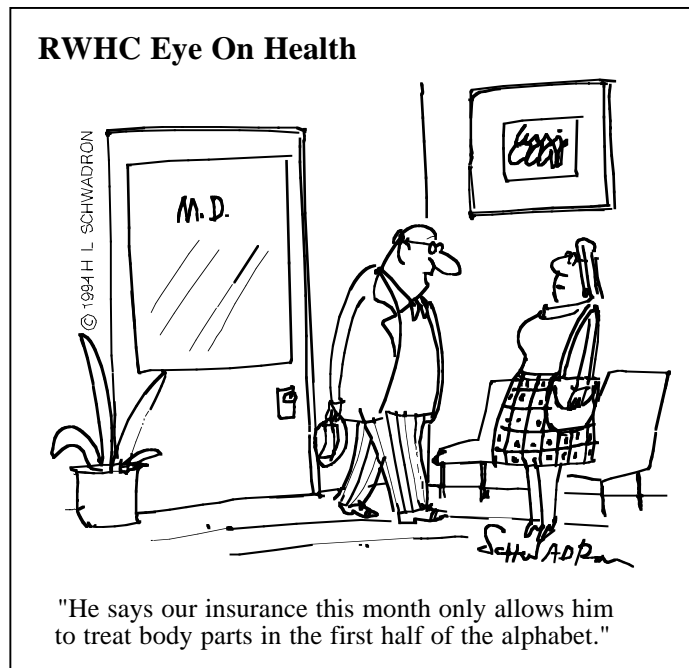
“Certainly, government has a job to do with leadership and federal investment in health information

technology and quality standards. For instance, we need interoperability standards so systems can communicate with each other, privacy protections, targeted investment and payment systems that reward quality care. The executive branch has taken a number of steps; all agree we need to do more.”

“The marketplace has an important role. Consumers must demand quality health care and the tools to provide it, such as pricing and performance informa-

tion powered by robust information technologies. If these things are done, we believe the quality of care we receive in this country can be radically improved.”

*Bill Frist is a Republican from Tennessee and Hillary Clinton is a Democrat from New York.*




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## Consumer Directed Care Only to Shift Costs?

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From an Issue Brief “Will Consumer-Directed Health Care Improve System Performance?” by Karen Davis, (Davis is president of the Commonwealth Fund, a private foundation supporting independent research on health and social issues), 8/04:

“Although consumer-directed health care plans have yet to generate broad consumer interest and enroll-

ment, they have garnered much recent attention for their potential to lower health spending by reducing utilization of health services. However, patient cost-sharing—the principal tool used by these plans to achieve lower spending—may also discourage consumers from getting necessary medical care.”

“While it is still too early to reach any definitive conclusions, current evidence raises significant concerns about relying on consumer-directed health care to address high costs, quality-of-care issues, and other fundamental problems in the health care system.”

“The consumer-directed approach is based on the notion that health care services are over-utilized; that giving financial incentives to consumers will reduce the use of marginal services; and that exposure to greater financial risk will motivate patients to seek lower-cost providers. There are various products available, but most of the discussion has centered on combining a high-deductible health insurance plan (e.g., \$1,500) with a health reimbursement account (HRA) to cover part of out-of-pocket expenses (e.g., \$500). What has been largely left out of the debate is that if patients pay more health care bills directly, they consume less care—even when it is needed. Increasing patient cost-sharing can increase the net price for patients; reduce utilization; lower total health spending; and lower the cost of insurance due to a lower percent of bills covered and declined utilization.”

“There are grave concerns regarding the effect of increased cost-sharing on lower-income individuals and those with serious illnesses, as they will bear the burden of higher out-of-pocket costs. Most health expenditures are incurred by a few very sick people. Ten percent of individuals account for 69 percent of health care costs. Care management for high-cost patients may be more effective and more equitable in controlling costs and improving care use than large insurance deductibles.”

“It seems clear that consumer-directed health plans enjoy favorable risk selection, which may lead to increasing market segmentation, with lower-income and sicker individuals served by managed care plans and higher-income, healthier individuals enrolled in the new plans. As a result, enrollment in managed care plans could undergo a long-term decline while premiums for these plans steadily increase. Rather

than focusing solely on consumer financial incentives, the real goal should be to promote the spread of high-performing health systems, hospitals, and physicians. New studies are finding wide variations of cost and quality across hospitals and physicians, yet few private insurers, managed care plans, or public programs reward superior quality or efficiency. The following are steps toward achieving a high-performance health system.”

1. **Public reporting of cost and quality data.** “While there is some limited reporting of quality-of-care data, the routine collection of comprehensive quality measures across a broad range of providers is necessary to improve performance.”
2. **Investment in IT.** “Other countries, aided by investments from their governments, are quickly surpassing the United States in adopting electronic medical records and electronic prescribing.”
3. **Development of guidelines and standards.** “Establishing a new National Institute on Clinical Excellence and Effectiveness could provide a scientific basis for the effectiveness of drugs, consultations, procedures, and tests.”
4. **Rewarding performance.** “Medicare and private insurers tend not to reward better care, including better management of high-cost conditions. Medicare can and should be a leader in promoting more effective care, and should help to encourage private payers to reward higher quality, as well.”
5. **Investment in research.** “The federal government pays \$455 billion for health care in the United States, but devotes only \$300 million to the budget of the Agency for Healthcare Research and Quality. More research regarding ways to improve care, eliminate waste and ineffective care, and promote greater efficiency is crucial to the goal of improving the performance of the U.S. health system.”

“If consumer-directed care is used primarily as a tool for shifting costs from employers to employees, it will quickly be discredited. Instead, the long-term strategy should focus on identifying, demanding, and rewarding performance from providers, with positive incentives for consumers taking a complementary role.”

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## Shawano Initiative To Help Farm Families

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A first person account shared with *Eye On Health* by Rhonda Strebel, rural health coordinator for the Shawano County Rural Health Initiative:

As health care issues facing today's farm families continue to escalate, business, health care and agricultural leaders in Shawano County have launched the Shawano County Rural Health Initiative, a unique program to address the growing concerns about the health of farmers and their families.

A grassroots planning team consisting of more than 30 Shawano-area residents with an interest in farm family health began meeting in 2002 to address these issues and develop strategy to combat the crisis.

A key result of the group's efforts over the past year and a half has been the creation of a rural health coordinator position. In that position, I make "house" calls to farm families to provide health information, education, referrals to area services, and most importantly, a trusted ear to listen to and keep in confidence concerns and issues these families face today. I also work closely with a committee of local business, agricultural and health care leaders. My position is funded through the Shawano Community Foundation, and I have an office at ThedaCare Physicians in Shawano.

More than 18 percent of Wisconsin dairy farm families have no health insurance. Another 41 percent have high deductible plans that provide only major medical coverage. And four out of five lack health insurance that covers checkups and preventive care.

Continually increasing costs for health insurance often prevent farm families from seeking help. Without insurance, farmers are not likely to seek medical treatment for minor accidents or chronic conditions such as high blood pressure, diabetes, farmer's lung, milker's knee, melanoma, hearing problems, arthritis, bruises or broken bones. They are also unlikely to seek preventive care for themselves or their dependents.

Many chronic illnesses can be prevented or controlled, and awareness is one of the best tools for prevention. I offer blood sugar and cholesterol testing, blood pressure screenings, and I help families understand how their family history and lifestyle contribute to certain health risks.

Because I was raised on a farm, I understand that farm families often lack the time, financial resources, and knowledge necessary to maintain a healthy lifestyle. I try to connect them with important community resources that can help farmers and their families lead healthier lives. By taking advantage of this program, farm families really have an opportunity to take control of their health.

By bringing certain services to these families, I hope I can help them improve their overall health by adopting healthier lifestyles and offering them access to services they may not otherwise receive.

*For more information about the Shawano County Rural Health Initiative, people may contact Rhonda Strebel at (715) 524-5272 ext. 6141.*

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## Dr Smith's Amazon Report

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*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 north-eastern Peru. The clinic operates with grassroots 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.*

"There has been a little excitement lately with a somewhat exotic disease. Juvencio owns several *bufalos*, the water buffalo descendants who survive better than cattle on the miserable, tough, coarse grass that is all that will grow once the forest has been hacked away. He received a letter from someone a couple of towns upriver, to say that a case of bovine rabies had been diagnosed there, and that government veterinarians were coming to vaccinate the buffaloes. Owners were cautioned that they should have a rope around the neck of each animal

before the vets arrived, to avoid having to chase them around the field, and that each vaccine would cost S/2.10, or about \$0.60 U.S.”

“Juvencio dutifully got ropes onto his animals and waited all day for the vets. Unfortunately, by the time they got to him, it was too late to vaccinate, and they went on downriver, promising to return another day. Which other day? – umm, well, soon.”

“When I next went to Iquitos, I tracked down the epidemiologist in charge of zoonoses, or illnesses that can be passed from animals to humans. Dr. Cardenas told me that the owner of the dead buffalo recognized the lurching gait, followed by paralysis, frothing at the mouth, then death, and knew how to prepare and send the animal’s head, because the health authorities had been giving talks on the topic ever since a case of bovine rabies had shown up last year in Maniti, across the river from us.”

“Anyway, they are working on vaccinating all the buffaloes they can reach. There are a couple of problems with this. First, of course, are the sheer logistics – they have been back once more since this started,

and so far, only one of Juvencio’s buffaloes has been vaccinated. Then, there is the fact that the vaccination is neither obligatory nor free, which means that some owners will choose not to spend the money on a problem that they do not see as being a threat to them personally. Also, Dr. Cardenas says that they are about 80% sure that the disease is being transmitted by vampire bats, since those are the most common vectors and since they are known to feed on cattle. The resources are therefore being put toward vaccinating cattle, buffaloes, horses and pigs. They are not trying to vaccinate dogs, since the vampires rarely feed on them. He says that if a case of human or canine rabies turns up, then they will begin a massive program to vaccinate the dogs and maybe put out mist nets as well, to catch the bats.”

**Rural Health Policy Institute, March 21-23, 2005  
Grand Hyatt Washington, Washington DC.**

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