

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

Your “Skin” in the Insurance “Game”?

From RWHC’s August 4th testimony on a proposed rule regarding market behavior of preferred provider organizations (PPOs) by the Wisconsin Office of the Commissioner of Insurance (OCI):

“This week’s hearing on regulating PPOs lived up to its prior billing—lots of noise, not yet much light. We are not in a position to comment on the dispute about the timing of the hearing but we would like to go on record supporting the rule. Like any proposal, it can be improved but as we understand it, the rule addresses fundamental problems that too many enrollees and providers face with some, not all, PPOs.”

“As we have been discussing with OCI for over a year, the need for all health plans to adequately provide for geographic availability which ‘reflects the usual medical travel times within the community’ is absolutely critical for the future of rural health care. Insurers being able to force rural residents to travel long distances for health care that is available in their home town, is just plain wrong.”

“I wish more people had heard the east coast carpetbagger at the hearing talk about Wisconsin residents needing to have more ‘skin in the game.’ I know many feel they already have their skin, most of their other vital parts and the

greater part of their wallet ‘in the game.’ A ‘game’ where the insurer’s rules keep changing and are only discovered after the dice are thrown is nothing to brag about.”

“It is clear that some PPO have no interest in working to make the market place more efficient—where relative cost, benefit and access are more transparent. What some seem to be saying beneath their well practiced rhetoric is that they prefer a market where the rules are vague and information hard to come by.”

“A presenter was asked if he agreed that enrollees should clearly know upfront what co-payments they face and he basically said ‘no,’ trying to deflect the question by saying ‘that there was a huge problem with hospitals.’ Hospitals know that the new generation

of higher deductible plans means that the public needs better information to estimate their out-of-pocket expense. We just wish that all PPO advocates knew it.”

“We encourage OCI and the Legislature to work collaboratively to resolve the remaining issues as soon as possible so that our state can have the insurance market place it needs, not necessarily the one envisioned on either coast.”

“Ironically, a number of individuals who spoke at the hearing said that the rule reflected a ‘misunderstanding of the market’ and postured themselves as defending that market. Nothing could be further from the truth; there is growing



“The idealists dream and the dream is told, and the practical men listen and ponder and bring back the truth and apply it to human life.” Anna Howard Shaw in 1905 at the thirty-seventh annual convention of the National Woman Suffrage Association.

evidence that the people of Wisconsin are becoming increasingly antagonized by current health insurers' dysfunctional market conduct."

"True supporters of 'market-oriented solutions' are not those just chasing short-term self-interest. No market has much of a future without the support of the average worker/voter. Appropriate, focused regulation is needed to address our current shortcomings and restore the credibility of the health insurance market."

Adding Primary Care Lowers Overall Costs

From a press release, "New study: States with higher Medicare spending offer lower quality care; Greater numbers of primary care doctors yield more effective care and lower spending," from Dartmouth College, 4/07/04:

Bottom Line. "States with higher Medicare spending often provide lower quality, less effective care to Medicare beneficiaries, according to a new study by Dartmouth College economists Katherine Baicker and Amitabh Chandra. The study, published in the April issue of *Health Affairs*, shows that spending more money does not necessarily translate into better care for the elderly.

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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"States spending more money per Medicare beneficiary are likely spending those dollars on intensive, expensive care instead of more effective care, the study's authors said. High-spending states also are likely to have a greater concentration of specialists."

"The study examined state-level differences in spending per Medicare beneficiary and the quality of care provided. Higher spending did not reflect higher quality care for patients. For example, New Hampshire, which spent about \$5,000 per Medicare beneficiary, had the highest overall quality ranking, while Louisiana, which spent the most per Medicare beneficiary at \$8,000 per person, had the lowest overall quality ranking." [**Wisconsin has the 12th lowest spending and the 8th highest quality.**]

"Baicker and Chandra said that higher spending is unlikely to cause lower quality care, but is an indicator of a particular style of health care provision and resources. **The composition of the physician workforce—the mix of specialists and general practice physicians in a given area—play a critical role in determining the use of highly effective care.**"

"**States with relatively more general practitioners showed greater use of high-quality care and lower spending per beneficiary.** Increasing the presence of general practitioners in a state by 1 per 10,000 people was associated with a rise in the state's quality ranking and a reduction in overall spending of \$684 per beneficiary. Conversely, increasing the presence of specialists by 1 per 10,000 people led to a drop in overall quality and an increase in spending of \$526 per beneficiary."

Other Findings. "States with lower spending often had better quality care—higher use of interventions and screening methods such as prescribing beta-blockers at hospital discharge for patients treated for a heart attack, ordering mammograms every two years for women aged 65-69 and conducting regular hemoglobin tests and biennial eye exams for people with diabetes."

"States with higher spending and lower quality care had more frequent hospitalizations and use of Intensive Care Units (ICUs) for patients in the last six months of life."

“Medicare patients in states that spent \$1,000 more per beneficiary spent an average of 1.3 more days in the hospital and were 3.9 percent more likely to be admitted to an ICU.”

“The researchers based their analysis on 24 quality measures developed by the Medicare Quality Improvement Organization (QIO), as well as data from the Dartmouth Atlas of Health Care on the number of days Medicare beneficiaries in their last six months of life spend in a hospital and what fraction of them are admitted to the ICU.”

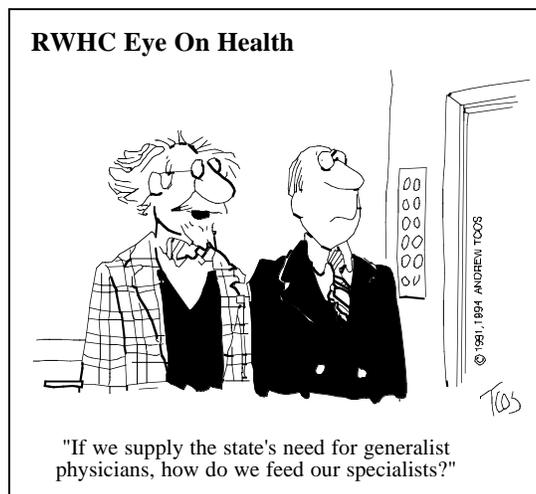
Not How Much but How Well. “Cutting spending is not the answer to improving care for Medicare beneficiaries. Despite the link between higher spending and lower quality care, the researchers emphasize that cutting Medicare spending to improve quality could have the undesirable effect of reducing the quality of medical care in high-spending states even more. Instead the authors suggest concentrating on policies that improve the quality of care for beneficiaries, such as establishing national practice benchmarks for basic quality measures, and encouraging greater access to general practitioners.”

Unique Consulting or Employment Opportunity: Program Coordinator Sought for a Rural Medical Education Planning Initiative. In addition to the Rural Wisconsin Health Cooperative, expected participants will include the UW Associate Dean for Rural & Community Health, the Wisconsin Office of Rural Health, St. Clare Hospital & Health Services, Southwest Wisconsin AHEC and Northern Wisconsin AHEC as well as additional organizations from around the state. The purpose is two fold: (1) to develop strategies and recommendations to increase the number of UW Medical School graduates who practice in Wisconsin’s rural communities and (2) to develop recommendations to promote residency education in rural settings. The engagement is expected to be part-time for nine months starting this fall at the RWHC Office in Sauk City. Potentially interested individuals should email timsiz@rwhc.com. The Program Coordinator Consultant/Job Description is available at: www.rwhc.com. *Opportunity contingent on funding which is still pending.*

“ ‘Improving quality of care has everything to do with how the money is spent,’ said Chandra. ‘And there is good evidence that, in many cases, we are not spending it wisely now. We need to determine how to make better use of health care dollars, especially with the baby boom generation about to enter the Medicare system in the next few years.’ ”

Healthier America One Community at a Time

From *America’s Health: State Health Rankings-2003 Edition* at www.unitedhealthfoundation.org/.



“*America’s Health: State Health Rankings 2003 Edition* is produced by the United Health Foundation in partnership with the American Public Health Association (APHA) and the Partnership for Prevention. This is the 14th in a series of comprehensive, state-by-state analyses of health status in our nation. The report documents the successes that have been realized through the hard work of health workers and by communities

throughout the country, and also lays out the challenges that continue to face our communities. It is our hope that individuals, families, community leaders, employers and public officials will use this report as a foundation for targeted efforts to improve their own health and that of their communities. Achieving and maintaining health is an essential priority for our nation and, as such, it is worthy of the best efforts of all of us.”

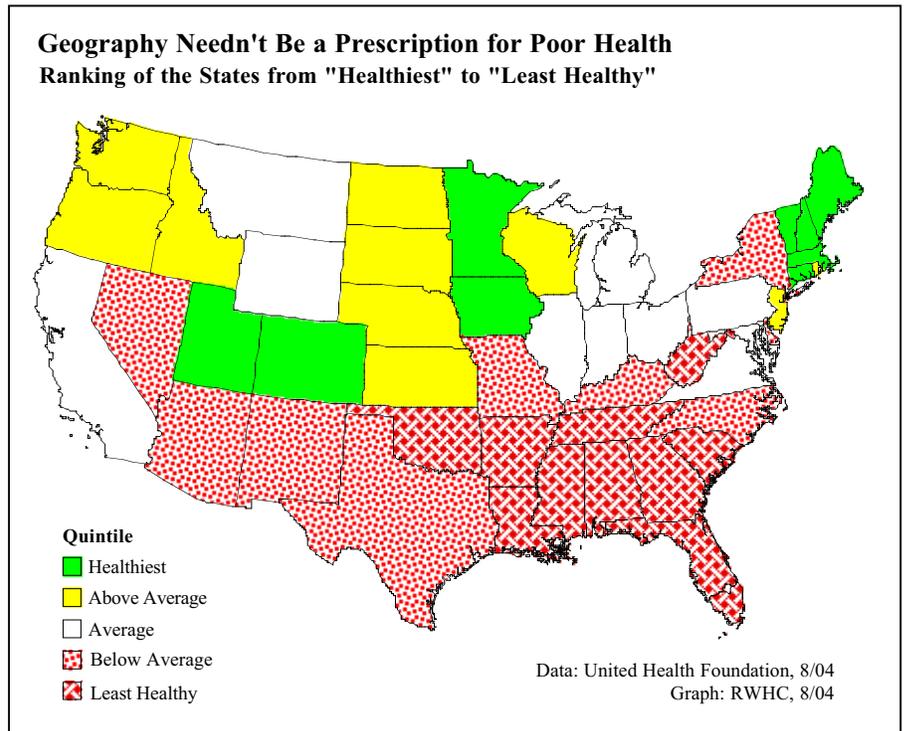
“As this report indicates, health status is significantly determined by the combination of personal behaviors and health decisions made by individuals, the social environment in which we work and live, and the decisions made by public officials. Each of us has a role to play and, as indicated in the special message from Secretary of Health and Human Services Tommy Thompson, ‘There is no time to lose.’ We are pleased that this year’s *State Health Rankings* includes a noteworthy paper from the eminent public health

scholar, William L. Roper, MD, Dean of the School of Public Health at the University of North Carolina - Chapel Hill. Dr. Roper celebrates the strengths of our nation's public health infrastructure, but also presents some important and urgent challenges that require attention. We urge you to read the commentaries of both Secretary Thompson and Dr. Roper carefully."

"As in previous editions of the *State Health Rankings*, this year's report makes it clear that every state, no matter where it stands in the rankings, has its own share of successes as well as opportunities for improvement. Our hope is that each of our states and communities can learn something from the experiences of others that will benefit the people of their state and the nation as a whole."

"The annual *State Health Rankings* is based upon data from the U.S. Departments of Health, Commerce, Education and Labor, as well as the National Safety Council and the National Association of State Budget Officers. We are once again indebted to our methodology panel of public health experts, who continue to guide and refine the criteria that are used to determine health status for this project. Their names are listed on the methodology page. The convening leadership of the School of Public Health at the University of North Carolina at Chapel Hill continues to be greatly appreciated."

"Finally, to help individuals and organizations work together to achieve healthier communities, we have once again asked the Health Research and Education



Trust (HRET), working in partnership with the American Hospital Association (AHA), to recommend important attributes of healthy communities. As our partnership indicates, we strongly believe that working together, sharing information and taking personal action is the formula for achieving the healthiest possible society."

Key Traits Shared by Healthy Communities. "The health of your community has a substantial impact on your personal health, and you can have a substantial impact on the health of your community. You can improve your own health by actively working to improve the health of your community. To help you get started, United Health Foundation has partnered with the HRET and its Association for Community Health Improvement, working in partnership with the AHA to provide this list of key traits shared by healthy communities, which you can use to guide your efforts in your own community:"

- 1) **"Practices ongoing dialogue.** Healthy communities begin the process of improving health and quality of life by having dialogues with local residents to identify common goals. Broad-based participation and discussion builds relationships among residents and generates a shared commitment to take action."

Wisconsin is 14th Healthiest, Down from 10th

Wisconsin's strengths are a low rate of uninsured population at 9.8 percent, a low violent crime rate at 231 offenses per 100,000 population, a strong high school graduation rate at 78.2 percent of incoming ninth graders who graduate within four years and a low incidence of infectious disease at 8.3 cases per 100,000 population.

Wisconsin's biggest challenge is low support for public health care that is 35 percent below the average state.

“Balanced Scorecards & Population Health.” A copy of this presentation by Tim Size to the Midwest Regional Meeting of the National Organization of State Offices of Rural Health in Madison, Wisconsin, on August 12th, 2004, is available at: <www.rwhc.com/papers/TS-8-12-04.pdf>.

- 2) **“Shapes its future.** Using a shared vision for the community, healthy communities set clear objectives. They recognize there are many factors they can control, and they understand there are valuable resources in their communities they can harness. In addition, they understand the important effects that economic development and environmental issues have on their future well-being. They take steps to ensure the future they want.”
- 3) **“Generates leadership everywhere.** Healthy communities recognize and support the leadership potential of *all* their members. They realize that leaders are found throughout community life. They actively cultivate new leaders, especially among young people and under-represented groups. They have also discovered that the most effective leaders facilitate discussion, encourage collaboration, and build strong coalitions and relationships.”
- 4) **“Embraces diversity.** Healthy communities understand that—to succeed in improving overall health and well-being they must include all segments of the community in their efforts. Diversity, whether racial, economic, in age of residents or in sexual orientation, is a potent source of vitality, strength, and renewal.”
- 5) **“Knows itself.** Healthy communities know that, in order to improve health and quality of life, they must collect and use information effectively. They select factors to measure based on what is important to the community. They focus more on assets than needs. They also recognize how important it is to track and measure health outcomes, even though outcomes data may take a long time to develop. At the same time, they do not use the lack of data as an excuse for inaction.”
- 6) **“Connects people and resources.** Health care services, community-based organizations, cultural offerings, recreation outlets, and social and fraternal groups are examples of vital resources healthy

communities provide. They know that a resource rich environment contributes to healthier and more satisfying lives for their residents.”

- 7) **“Creates a sense of community.** A shared set of values and behavior standards, neighborliness, an acknowledgement of interdependence, and a commitment to the common good help create a sense of community. When people feel strongly connected with each other, they are more likely to act in the interests of the entire community, which helps local institutions and organizations prioritize needs and focus resources effectively.”

“In working toward a healthy community, there are more resources in our communities than we may realize. HRET has prepared links to ‘Resources for Action’ at <www.unitedhealthfoundation.org>. For more information and stories from other communities go to <www.hret.org>.

Communities Organize Against #1 Killer

From the American Heart Association (AHA) “Guide for Improving Cardiovascular Health at the Community Level; A Statement for Public Health Practitioners, Healthcare Providers, and Health Policy Makers.” The complete article is available at:

<http://circ.ahajournals.org/cgi/content/full/107/4/645>

“This Guide is intended to provide persons and organizations interested in improving the cardiovascular health of their communities with a comprehensive list of goals, strategies, and recommendations that might be implemented on a community-wide basis. It targets not only health professionals but also public health practitioners, voluntary health agencies, and community leaders in general.”

“This Guide differs from the four AHA clinical guidelines (also available at the above web address) because it provides a comprehensive approach to reducing the burden of cardiovascular disease (CVD) through improving the local policies and environment as a means to promote cardiovascular health. Changes toward a healthier environment could be

expected to enhance the clinically oriented guidelines because both the primary and secondary prevention guidelines recommend that healthcare providers encourage behavior change in individual patients.”

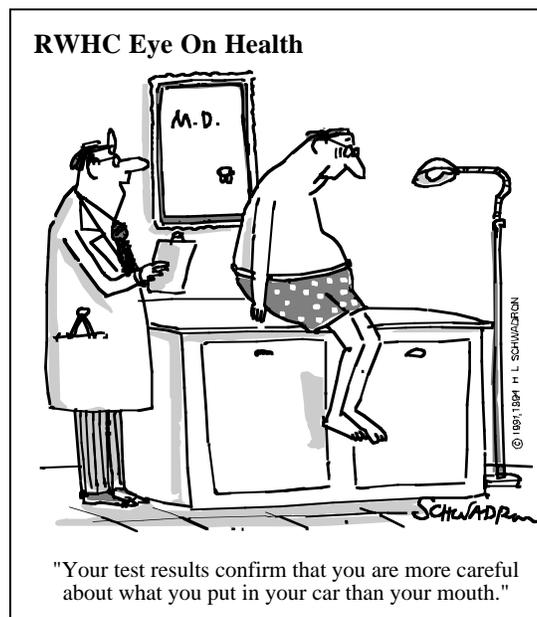
“Improvements in facilities and resources in the places where people work and live should enhance the achievement of many goals, including: cessation of tobacco use and avoidance of environmental tobacco smoke; reduction in dietary saturated fat, cholesterol, sodium, and calories; increased plant-based food intake; increased physical activity; access to preventive healthcare services; and early recognition of symptoms of heart attack and stroke. Healthcare providers and their patients have better opportunities for successfully implementing the clinical guidelines when they live in such communities.”

“Although complementary to and supportive of the clinical guidelines, the Community Guide provides a fundamentally different strategy for the prevention of heart disease and stroke. It uses the population-based approach to risk factor modification, in which the entire distribution of risk factors and risk is shifted toward lower levels through population-wide interventions. This is contrasted with the high-risk approach, as carried out in clinical settings, in which individuals’ risk levels are assessed and those at highest risk are treated intensively.”

“A worthy goal is to prevent the onset of risk factors in the first place, referred to as health promotion. This strategy has the potential not only to prevent the first heart attack or stroke in the person at average risk (a population in which large numbers of CVD deaths still occur) but also to avoid the need for intensive and expensive pharmacotherapies to control risk factors such as hypertension, hyperlipidemia, and diabetes, once they become established. The high-risk and the public health strategies mutually enhance each other; the effectiveness of one is compromised when the other is not fully realized as well.”

The 2004 Wisconsin State Cow Chip Throw
will be held on **Friday night September 3rd & Saturday, September 4th** at Marion Park in Prairie du Sac.

“The Community Guide emphasizes the social and environmental origins of the CVD epidemic. The Nurses’ Health Study, for example, has demonstrated that women who maintain a desirable body weight, eat a healthy diet, exercise regularly, do not smoke, and consume a moderate amount of alcohol have an 84% reduction in their risk of CVD! These data suggest that the causes of the vast majority of cases of heart disease and stroke have been identified and can be attributed to a few deleterious behaviors and lifestyles.”



“Comparisons of populations even within the United States point to the extraordinary range of risk to which *populations* are exposed. For example, the age-adjusted death rates from heart disease for men in the state with the highest rate (Mississippi, 878 per 100,000) is nearly twice that of those in the states with the lowest rate (Hawaii, 482 per 100,000; Utah, 492 per 100,000). At the county level, the range of heart disease mortality rates was even wider (377 to 1102 deaths per 100,000). These huge differences between

populations persist for men and women and for racial and ethnic subgroups. Behavioral and cultural differences are more likely explanations for these differences than are genetic or clinical factors.”

“Secular trends also point to behavioral and social factors as explanations for the decline in heart disease mortality rates in the United States. Goldman and Cook examined the contributions of lifestyle changes versus medical interventions as explanations of the CVD mortality decline between 1968 and 1978. These authors attributed 39.5% of the decline to medical interventions such as coronary care units and emergency cardiac care, bypass surgery, postcoronary medical therapies, and antihypertensive drugs, as compared with 54% of the decline explained by reductions in smoking and serum cholesterol levels (largely due to

dietary change), following public education campaigns by voluntary health organizations such as the AHA. Thus, a population-wide behavioral strategy is a worthy partner to complement clinical strategies.”

“The Community Guide is organized around three dimensions: (1) the behaviors targeted for change; (2) the community settings in which interventions might be implemented; and (3) the interventions themselves. Two features of the Guide are recurrently emphasized. First, the goal is to promote *lifestyle* and *behavior* change at the individual and community levels and *policy* change at the community level. Although clinical guidelines identify goals for risk factors such as levels of desirable blood pressure or blood cholesterol, the Community Guide’s goals are related to behaviors of the inhabitants of the community that affect these risk factors.”

“Finally, the gap between what is possible and what is happening is large, presenting a challenge to the AHA, governmental agencies, the healthcare system, and community organizations. Two community-based studies in the United States, one in Worcester, MA, and another in Olmstead County, MN, suggest that the rates of *new* cases of heart disease have not fallen since 1990, and, for women, may have actually risen.”

“There is abundant evidence that US adults frequently do not recognize heart disease as the number-one cause of disability and death and do not know their own risk or risk factors. Many physical activity programs in schools have been reduced or eliminated, such that daily participation in physical education classes has declined among high school students from 42% of students in 1991 to 25% in 1995. School breakfast and lunch programs should provide heart-healthy meals but frequently do not. Recommendations by health professionals to modify diets or increase physical activity continue to be hampered by lack of grocery stores or restaurants with heart-healthy choices, and by lack of safe, attractive places to be physically active. Tobacco is still accessible to our youth, and many persons are still exposed to environmental tobacco smoke at work and home.”

“This Community Guide is designed to assist community leaders to meet these challenges. It is hoped that it will provide a framework for concerned healthcare providers, public health practitioners,

AHA volunteers, policy makers, and other community leaders to approach this important but imposing task in an orderly, effective manner. In doing so, the Guide will provide an essential component, along with the clinical guidelines, for the comprehensive approach to reducing the burden of heart disease and stroke in our communities.”

Update: Rural Health Works

From a “Preserving Local Healthcare: Case Studies of Rural Health Works Implementation in Three Communities” by two Truman Fellows at the Federal Office of Rural Health Policy, Craig Williamson and Joy McGlaun. The complete report is available at:

<http://ruralhealth.hrsa.gov/pub/RHWreport.htm>

“A growing awareness of the important economic impact of the rural health care sector has emerged. In many rural communities, the health sector is one of the largest employers and its payroll injects significant capital into local economies. A typical rural hospital may employ 15 to 20 percent of the local workforce and possess a multimillion dollar payroll. Much of the money paid to health sector employees is then spent in the community, which generates additional local jobs and revenue. The presence of quality health care is a vital component of numerous economic development strategies. Manufacturers and high tech industries are unlikely to locate in an area that does not have adequate access to health care. Health care is also a key factor in attracting and retaining retirees.”

“Recognizing the need to increase awareness of the crucial economic role of the rural health care sector, Rural Health Works (RHW) formed in 1998 as a partnership between the Health Resource and Services Administration’s Office of Rural Health Policy (ORHP), the USDA Cooperative Research, Education, and Extension Service (CSREES), and the Rural Policy Research Institute (RUPRI). The project was headed by Dr. Gerald Doeksen, an Extension Economist at Oklahoma State University in Stillwater, OK. Initially, Rural Health Works began as a pilot project in five states: Kentucky, Missouri, Ne-

vada, Oklahoma, and Pennsylvania. After meeting with success in these states, the project was broadened nationally.”

“In subsequent years, Dr. Doeksen and Rural Health Works staff traveled to 43 states to conduct ‘Train the Trainer’ workshops. These trained participants to use IMPLAN® data to determine the economic impact of health care at the zipcode, county, regional, and state levels. IMPLAN is an economic impact analysis tool developed by the US Forest Service in the early 1990s and now sold commercially.”

“While the economic impact studies are the centerpiece of the Rural Health Works process, the project’s main objective is to move beyond economics and actively engage communities to preserve local health systems. The bypass of rural hospitals and providers in favor of large urban centers is a common problem faced by rural providers. Despite contrary evidence, many rural Americans believe that ‘bigger is better’ when it comes to health care. By educating communities about the critical economic importance of health care it is possible to build support and increase the viability of local health care infrastructure.”

“As awareness of the economic impact of rural health care and Rural Health Works grows, communities are implementing the tools in a variety of ways. Some undergo a formal community engagement process and others use the economic impact data for grant applications. This document profiles the story of three communities: Tishomingo, Oklahoma; Yerington, Nevada and McConnellsburg, Pennsylvania.”



Photo by Kris Jugenheimer

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