Health Care Reform Inevitable, Just Not Yet

From “Perspective: What Are the Prospects for Enduring Comprehensive Health Care Reform?” by Victor R. Fuchs in Health Affairs, Nov/Dec 2007:

“Enduring Reform of health care must be comprehensive. It must cover the uninsured without exceptions or conditions. It must reduce the huge inefficiencies in the way the country funds health care by eliminating employment-based insurance and income-tested subsidies. It must improve efficiency in medical practice by providing physicians with the information, infrastructure, and incentives they need to deliver cost-effective care. Reform must also eliminate gross lapses in quality and must tame but not destroy the development and diffusion of expensive new medical technologies. This is a tall order. A century of failed attempts at major reform tells us that these goals will not be easily attained.”

Obstacles To Reform

Special interests. “What are the obstacles? First, and in many observers’ view, foremost, are ‘special interests.’ Who are they? At one time, organized medicine played a leading role in blocking change. That is less true today; indeed, many physicians are among the leading advocates of reform. The insurance industry now spearheads the opposition, with drug, device, and equipment manufacturers also being major defenders of the status quo. ‘Special interests’ is an easy answer—perhaps too easy. After all, every country has ‘special interests.’ Why are they so much more effective in the United States? I believe that the explanation lies at least in part with the U.S. political system, which creates so many opportunities for ‘special interests’ to exert disproportionate influence.”

“In comparison with those of other nations, the U.S. political system is notable for the importance of money for campaigns and the importance of the primaries in creating partisan politics in Congress. Also important is the division of power among the administration, the House of Representatives, the Senate, and the numerous committees in each House. From the primaries to the elections to the hearings to the passing and signing of legislation, there are numerous ‘choke’ points where well-organized ‘special interests’ can block the will of the majority.”

Machiavelli’s (and others’) law. “A second important obstacle is what should be called ‘Machiavelli’s Law of Reform.’ In The Prince, Machiavelli’s masterpiece of shrewd political observations, he wrote, ‘The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order.’ Thomas Jefferson expressed a similar idea in the Declaration of Independence: ‘All experience hath
shown that mankind are disposed to suffer, while evils are sufferable than to right themselves by abolishing the forms to which they are accustomed.’ In recent times, the psychologists Daniel Kahneman and Amos Tversky have formulated this idea more rigorously in their ‘prospect theory.’ After numerous experiments with human subjects, they concluded that most people attach more weight to fear of loss than they do to hope of gain. Most of the time, inertia rules.”

**Lack of unity.** “A third major obstacle has been health care reformers’ inability to unite behind a single approach. This is not a new phenomenon. In commenting on the failure of health care reform efforts early in the past century, Daniel Hirschfield in *The Lost Reform* wrote, ‘Some saw health insurance primarily as an educational and public health measure, while others argued that it was an economic device to precipitate a needed reorganization of medical practice…. Some saw it as a device to save money for all concerned, while others felt sure that it would increase expenditures.’”

“Consider the present situation. Suppose as much as 75 percent of the public favors universal coverage (probably an overestimate). If 25 percent want mandates, 25 percent favor Medicare for all, and 25 percent strongly prefer a voucher system, prospects for enduring comprehensive health care reform? In the short term, the chances are virtually nil. Until 2009 the United States will be ruled by an unpopular, doctrinaire Republican president and a narrowly elected Democratic congress with no clear mandate except opposition to the Iraq war. Divided government is unlikely to enact anything so complex and controversial as comprehensive health care reform. Even the next administration, be it Democratic or Republican, will have its hands full with foreign policy problems: withdrawal from Iraq and Afghanistan, containment of Iran and North Korea, negotiations with Russia, and rebuilding alliances with friendly nations. The executive and legislative branches will have little time or political capital to spend on major health care reform for the rest of this decade.”

**Over the intermediate term.** “Over the intermediate term—say, five to ten years—it is more likely that health policy will come to the fore, but even then the prospects for enduring comprehensive reform are no better than fifty-fifty unless the nation were to face a major economic, political, social, or public health crisis. In that case, the chances for reform would rise dramatically. The danger is that a reform package hastily crafted and enacted in a time of crisis might not have the ingredients to make it enduring.”

“One development that would make reform more attainable is a split among the ‘special interests.’ There may come a time when the large integrated health plans and major insurance companies will see no advantage in fighting to preserve the opportunity for hundreds of small insurance companies to continue in business. A split in the business community (of which signs are already appearing) will produce many leaders who see little point in trying to preserve employment-based insurance. There may also come a time when most physicians and hospital administrators, fed up with the present chaotic, costly system, will say, ‘There must be a better way to pay for health care.’”

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The Rural Wisconsin Health Cooperative (RWHC) was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of 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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**Long-term prospects.** “Over the long term, major reform is practically inevitable. No nation can continue to allow health care to drain away resources that would be more socially productive in education, the environment, security, and other policy areas. It will come sooner rather than later if policymakers recognize that the United States must find its own approach, one that is congruent with basic American values: equality of opportunity combined with exercise of personal freedom.”

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**Healthcare Work Force, a Critical Prognosis**

From “For the Healthcare Work Force, a Critical Prognosis” by Daniel W. Rahn And Steven A. Wartman in *The Chronicle of Higher Education*, 11/1/07:

“The United States faces a looming shortage of many types of health-care professionals, including nurses, physicians, dentists, pharmacists, and allied-health and public-health workers. The results will be felt acutely within the next 10 years. Colleges and health-science programs will all be affected by the demographic, technological, and bureaucratic trends driving the pending crisis. But they can also be part of the solution.”

“The growth of the American population and the aging of the baby-boomer generation will continue to increase the demand for health-care services and providers. More than 100 million people in America already have chronic illnesses or suffer from degenerative conditions such as cancer, cardiovascular disease, and arthritis, which require long-term management by different kinds of health-care providers — and that number will only get larger with time. It is estimated that over the next decade we will need at least 20,000 more physicians specifically trained to care for elderly patients. Fewer than 8,000 geriatricians are in practice today. The federal Bureau of Labor Statistics also projects that, during that same time period, we will need 3.5 million more workers to meet the increasing demand, in addition to replacements for the two million health-care workers who will leave their positions.”

“After September 11, 2001, there was a slight uptick in applications and enrollments at many health-professions schools, following a period of decline during the 1990s. This fall the nation’s medical schools experienced a 2.3-percent increase in enrollment and an 8.2-percent increase in applications, the Association of American Medical Colleges reports. That is heartening news, but there have not been changes of the magnitude needed to make a difference in our health work force.”

“Different expectations and lifestyle preferences on the part of today’s health-care workers are partly to blame. Thirty years ago, in what was more of a manufacturing economy, young people saw health care as high tech. In today’s information age, it is now viewed as more low tech. The messiness and stress of caring for people with complex illnesses may not be attractive to young people who have many career options. The hurdles to degrees in the health professions—including extensive math and science course work, expensive education, daunting debts, and lengthy training—are also likely deterrents.”

“Other potential problems are related to generational change. The future health-care work force will come largely from Generations X and Y, both smaller demographic groups than the baby boomers. Compared with the boomers, who placed a high priority on careers and had a greater tendency to stay with one career for a lifetime, Xers and Yers appear more interested in work that can accommodate their families and personal lives. They often seek flexibility, telecommuting, family leave, and part-time options—almost none of which can be met by the demands of a career in the health-care professions. Even if the same proportion of individuals was recruited into health-care careers from the two younger generations as from the boomers, however, we would still not have enough people to replace those who will soon retire, let alone expand our capacity.”

“More bad news: Our country faces worsening shortages of faculty members in the health sciences. In July the Association of Academic Health Centers released a report that said 94 percent of CEOs at academic-health centers deemed faculty shortages a problem in at least one health-professions school; 69 percent thought those shortages were a problem for their entire institutions.”

RWHC Eye On Health, 11/9/07
“Several factors account for the widespread faculty shortages, including a low level of interest in academic careers among those entering the health-care professions, heavy faculty workloads, disparities in salaries between academe and private practice or industry, and retirements among baby boomers.”

“In colleges of nursing, for example, where master’s or doctoral degrees are required, the mean age of faculty members with master’s degrees in nursing is 48.5. Retirement projections for nursing-faculty members show that from 2004 to 2012, 200 to 300 Ph.D.’s will be eligible for retirement each year. We do not have enough nursing educators in the pipeline to stem such losses.”

“The situation is similar in pharmacy programs. Of the nation’s 82 schools of pharmacy, 67 reported in a survey that they had an average of 6.2 vacant faculty positions last year. Thirty percent of the open academic positions had been vacant for at least a year. Most important, 92 percent of those vacancies represented teaching positions that directly affect the number of pharmacy students a school can enroll.”

“The final crucial factor precipitating the health-care-work-force crisis is a lack of comprehensive work-force planning on the parts of academe, government, and the health-care professions. We need strategic direction instead of the current piecemeal approach at the national and state levels; both federal and state policy making has tended to respond to immediate crises or issues related to one particular profession or constituency. Commissions and task forces abound, yet many reports gather dust on shelves; the infrastructure for putting good ideas or new policies into effect is at best uneven.”

“Shortages in the health-care work force are not local or isolated issues. They require attention at the highest levels of the federal and state governments. College leaders should work together with government officials to make that a top priority on the domestic-policy agenda.”

“Some states—with the help of their university systems—have looked across the professions to confront health-care-worker shortages. In 2005 the University System of Georgia appointed a task force on health-professions education to analyze future needs and inform decision making in response to the needs of the state. In its final report, the Task Force on Health Professions Education cited projected faculty retirements, smaller pools of potential faculty members, inadequate facilities to support expanded enrollments, and a limited number of clinical sites to support the clinical-education needs of students enrolled in the state’s health-professions programs as barriers to an effective and coordinated response to market demand. Programmatic integration also was identified as a confounding issue: The report identified a crucial need for the university system to work closely with the state’s technical-college system, the primary educator of health-care technicians and paraprofessionals, to ensure transparency and clarity in educational requirements so that students are able to move between the educational systems.”

“Such collaborations between colleges and states are a good beginning. But higher education and the government must become partners on the federal level as well. The institutions that educate the nation’s future health-care professionals must work together to devise innovative solutions to the myriad challenges we face—and must finance them, too.”

“Colleges and health-sciences centers must also deal with the work-force shortage issue at their own institutions. They should address the growing shortages of health-professions faculty members by supporting faculty-development programs and expanding accelerated training programs. Continuing education is a key strategy in retaining health-professions faculty members, as are mentorship programs — particularly
for retaining junior members of the professoriate and those groups that have been historically underrepresented in the health-care professions.”

“Offering loan-repayment and loan-forgiveness programs would also be a draw. The high incidence of debt among graduates often drives health-care professionals to the most lucrative employment settings. Forgiving debt or offering generous loan-repayment plans creates more flexibility for colleges and universities in efforts to attract professionals to academic careers. And to augment their core faculty members with non-salaried, community-based clinicians who can provide valuable field-based clinical experiences, as health-professions programs must do, institutions can offer enticements like discounted or free registration in the continuing-education programs, tuition discounts or waivers, and access to other institutional resources (recreational facilities, for instance).”

“Colleges and health-science centers must also focus on increasing and improving the applicant pool, not simply in terms of sheer numbers and mix of health professions, but also with regard to diversity.”

“Alarming disparities in health status continue to plague our nation. A health-care work force that mirrors the population it serves is widely believed to increase access to care and improve quality of care; therefore, increasing the recruitment of individuals from diverse backgrounds to the health professions is crucial in light of the increasing diversity of the American population. Colleges and health-science centers must focus on untapped populations, such as underrepresented minorities and health professionals trained abroad. Accelerated training programs could be offered to ensure that the clinical and language skills of such health-care providers are at acceptable levels. In areas with rapidly growing Hispanic populations, bilingual students could be targeted as medical interpreters, providing invaluable exposure to the health-care system — and increasing the likelihood that they will pursue careers in the health professions.”

“The health-care shortage we face is serious. Some experts may argue that there is no cause for alarm, because work-force shortages are cyclical, market-driven, and easily ameliorated. But that perspective is not valid today. The work-force shortfall in health care cannot be resolved in the marketplace alone. It is time for organized action, not only within colleges, but also at our nation’s highest levels.”

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**Dental Associations—Cure or Curse?**

From “Boom Times for Dentists, but Not for Teeth” by Alex Berenson in *New York Times*, 10/11/07:

“For American dentists, times have never been better. The same cannot be said for Americans’ teeth.”

“With dentists’ fees rising far faster than inflation and more than 100 million people lacking dental insurance, the percentage of Americans with untreated cavities began rising this decade, reversing a half-century trend of improvement in dental health.”

“Previously unreleased figures from the Centers for Disease Control and Prevention show that in 2003 and 2004, the most recent years with data available, 27 percent of children and 29 percent of adults had cavities going untreated. The level of untreated decay was the highest since the late 1980s and significantly higher than that found in a survey from 1999 to 2002.”

“Despite the rise in dental problems, state boards of dentists and the American Dental Association, the main lobbying group for dentists, have fought efforts to use dental hygienists and other non-dentists to provide basic care to people who do not have access to dentists.”

“For middle-class and wealthy Americans, straight white teeth are still a virtual birthright. And dentists...”
say that a majority of people in this country receive high-quality care.”

“But many poor and lower-middle-class families do not receive adequate care, in part because most dentists want customers who can pay cash or have private insurance, and they do not accept Medicaid patients. As a result, publicly supported dental clinics have months-long waiting lists even for people who need major surgery for decayed teeth. At the pediatric clinic managed by the state-supported University of Florida dental school, for example, low-income children must wait six months for surgery.”

“In some cases, the results of poor dental care have been deadly. A child in Mississippi and another in Maryland died this year from infections caused by decayed teeth.”

“The dental profession’s critics — who include public health experts, some physicians and even some dental school professors — say that too many dentists are focused more on money than medicine.”

“ ‘Most dentists consider themselves to be in the business of dentistry rather than the practice of dentistry,’ said Dr. David A. Nash, a professor of pediatric dentistry at the University of Kentucky. ‘I’m a cynic about my profession, but the data are there. It’s embarrassing.’ ”

“A defender of the profession is Dr. Terry D. Dickinson, a practicing dentist who is also the executive director of the Virginia Dental Association. He says he believes that dentists are charitable and want to provide care to poor patients. But dentists are also in business; they must pay rent and employee salaries, and they deserve fair fees, he said.”

“ ‘Dentists, of course, are no more obligated to serve the poor than are lawyers or accountants. But the issue from a public health standpoint, the critics say, is that even as so many patients go untreated, business is booming for most dentists. They are making more money while working shorter hours, on average, even as the nation’s number of dentists, per person, has declined.’ ”

“The lack of dental care is not restricted to the poor and their children, the data shows. Experts on oral health say about 100 million Americans — including many adults who work and have incomes well above the poverty line — are without access to care.”

“A federal survey shows that 27 percent of adults without insurance saw a dentist in 2004, down from 29 percent in 1996, when dental fees were significantly lower, even after adjusting for inflation. For adults with private insurance, the rate was virtually unchanged, at 57 percent, up from 56 percent. Since 1990, the number of dentists in the United States has been roughly flat, about 150,000 to 160,000, while the population has risen about 22 percent. In addition, more dentists are working part time.”

“Partly as a result, dental fees have risen much faster than inflation. In real dollars, the cost of the average dental procedure rose 25 percent from 1996 to 2004. The average American adult patient now spends roughly $600 annually on dental care, with insurance picking up about half the tab.”

“ ‘Dentists’ incomes have grown faster than that of the typical American and the incomes of medical doctors. Formerly poor relations to physicians, American dentists in general practice made an average salary of $185,000 in 2004, the most recent data available. That figure is similar to what non-specialist doctors make, but dentists work far fewer hours. Dental surgeons and orthodontists average more than $300,000 annually.”

“ ‘ ‘Dentists make more than doctors,’ said Morris M. Kleiner, a University of Minnesota economist. ‘If I had a kid going into the sciences, I’d tell them to become a dentist.’ ”
“But despite the allure of rising salaries, the shortage of dentists will almost certainly worsen, because the nation has fewer dental schools and fewer dentists in training than a generation ago. After peaking at 5,750 in 1982, the number of dental school graduates fell to 4,440 in 2003, as several big dental schools closed their doors. The average dentist is now 49 years old, according to the American Dental Association, and for at least the next decade retiring dentists will probably outnumber new ones.”

“Even if more students wanted to enter the profession, states are not moving aggressively to expand dental schools or open new ones. Training dentists is expensive, because dental schools must provide hands-on training — unlike medical schools, which send doctors to hospitals for training after they graduate. Hospitals receive federal subsidies for the training they provide to medical interns and residents, but the equivalent system does not really exist in dentistry.”

“Meanwhile, the A.D.A. does not support opening new dental schools or otherwise increasing the number of dentists. The association says it sees no nationwide shortage of dentists, though it acknowledges a shortage in rural areas. Dentists note that in the early 1980s, when schools were graduating nearly twice as many dentists relative to the overall size of the population as they are now, some dentists struggled to keep their practices afloat.”

“Dr. Kathleen Roth, president of the A.D.A., said that the association is working to increase Medicaid’s reimbursement rates to make it more cost-effective for dentists to treat low-income patients.”

“But critics say the association’s plans would do little to solve the problem of access to care. Moreover, even in states that have raised Medicaid payments, most dentists still do not accept Medicaid patients. Virginia, for example, overhauled its Medicaid program in 2005, raising rates 30 percent. But only about 25 percent of all Virginia dentists now accept Medicaid patients, compared with 15 percent before the changes.”

“Some dentists do not accept Medicaid patients because they frequently miss appointments, which means lost revenue, said Dr. L. Jackson Brown, the former managing vice president for health policy at the A.D.A.”

“With little dental care available for poor children, pediatricians are teaching themselves how to apply fluoride varnish on baby teeth, a simple procedure that can prevent cavities, said Dr. Amos S. Deinard, a pediatrician and associate professor at the University of Minnesota.”

“‘The dentists don’t want to see these kids,’ Dr. Deinard said.”

“Dr. Caswell A. Evans, a dentist and associate dean at the University of Illinois-Chicago, said dentists must stop fighting efforts to expand care to patients they are not currently treating. The system is failing many patients, he said. ‘Right now we have a double standard of care,’ Dr. Evans said. ‘Some people can get it and some people can’t.’ ”

America’s Health: a Tale of Two Counties

From “Two Counties Symbolize Health Divide” by Tom Breen in the Associated Press, 11/8/07:

“It’s more than geography that separates McDowell County in southern West Virginia from Monongalia County on the Pennsylvania border. The two are separated by the overall quality of residents’ health as well. From obesity to tobacco use, McDowell is ranked as West Virginia’s least healthy county while Monongalia is likely the healthiest overall.”

“These two counties in turn represent a broader divide in the state, in which northern counties have a significant advantage in overall health, while southern counties lead in negative indicators like chronic disease and lack of health insurance. There are complex reasons for the disparity, but doctors and health professionals say much of it can be traced to poverty versus wealth and isolation versus access.”
‘Poverty is a risk factor for a lot of common chronic diseases, including obesity,’ said Cheryl Mitchem, director of program development for the Tug River Health Association, which operates three health clinics and a personal fitness center in McDowell County. Obesity, in turn, leads to other health problems that are widespread in southern West Virginia. ‘If you look at asthma, diabetes, high blood pressure, hypertension—they all come back to obesity,’ she said.”

Wisconsin’s “Club Scrub” Honored

Sauk Prairie Memorial Hospital & Clinics (SPMHC) was honored with a best Practices Award by the Wisconsin Society of Healthcare Human Resources Administration (WSHHRA) for its piloting of “Club Scrub,” now being replicated by other RWHC hospitals. This innovative program started with a focus on 7th and 8th graders in order to foster interest in health care at an earlier age.

Robbi Eccher from SPMHC and Dawn Johnson from RWHC shared a presentation at WSHHRA’s annual “Best Practices” conference on how “Club Scrub” can be readily started by any hospital.

Funding for the pilot and replication to the other rural sites for the Middle School program came from the Rural Hospital Flex Program through the Wisconsin Office of Rural Health; Southwest AHEC is currently funding an expansion for high school students.

RWHC Passages

Gary Bezucha, Boscobel Area Health Care administrator and member of the RWHC executive committee, is moving up north to become CEO of North Central Health Care in Wausau. He will be missed at RWHC but at least has the good sense to stay in Wisconsin.