Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - August 1st, 1999

Will Medicare Vouchers Work for Rural?

One of the hottest Medicare reform proposals would allow for Medicare to offer a defined federal contribution rather than a defined benefit. The debate has just begun around this idea but once again the Rural Policy Research Institute is early out of the box in giving us a useful framework. The following is from *A Rural Perspective on Medicare Policy: An Initial Assessment of the Premium Support Approach (P99-7)* by Keith Mueller with Andrew Coburn, J. Patrick Hart, Timothy McBride, Clint MacKinney, and Mary Wakefield. The complete report is available at:

www.rupri.org/pubs/archive/reports/P99-7/index.html

"The Health Panel of the Rural Policy Research Institute (RUPRI) has reviewed the premium support proposal offered by Senator Breaux and Representative Thomas in the final meeting of the Bipartisan Commission on the Future of Medicare. This Policy Paper contains our analysis of the rural implications of that plan, and is intended to inform further debate regarding a general approach to Medicare redesign using the premium support model."

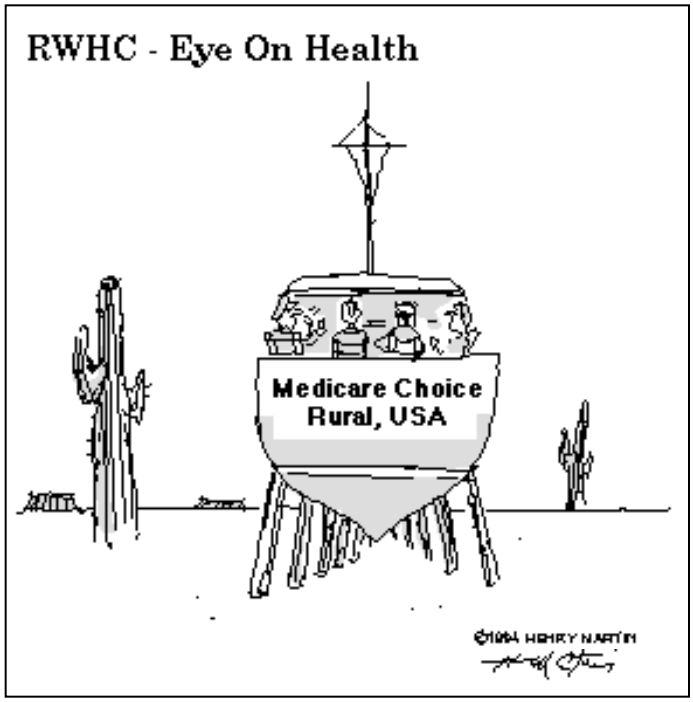
"Three principle components of the premium support approach are discussed: 1) determining a premium and the government payment toward the cost of any premium; 2) assessing the value of competitive insurance markets for rural Medicare beneficiaries; and 3) assessing likely impacts of a competitive approach on financial support for the rural health care delivery infrastructure."

Determining a premium and government payment toward the cost of any premium

"Premiums would be submitted by health plans wishing to compete for Medicare enrollees, either in a specific service area, or nationally. Plans would be required to submit bids for both a basic benefits plan (set to be the currently offered Medicare benefits) and a high option plan (which would include a benefit for prescription medication). A Government-run Fee-For-Service (FFS) plan would be available everywhere, and would be required to include a high-option alternative. A national weighted average would be calculated based on enrollment into each plan."

"On average, beneficiaries would be expected to pay 12 percent of the total cost of standard option plans. For plans that cost at or less than 85 percent of the national weighted average plan price, there would be no beneficiary premium. For plans with prices above the national weighted average, beneficiaries' premiums would include all costs above the national weighted average." (From the Bipartisan Commission on the Future of Medicare: <http://medicare.commission.gov>.)

"Adjustments made to premium payments would be for the age, sex, institutional status, Medicaid enrollment, employment and eligibility of enrollees, just as is now done with Medicare payments for risk contracts. Geographic adjusters would correct for variation in the cost of doing business (not historical expenditures), and health status adjusters would be created and used."



"Progress might have been all right once but it has gone on too long." *Ogden Nash (1902-1971)*

"The proposal includes two measures to assist persons vulnerable to higher premiums:

a. Subsidies: The government would increase its payment toward the premiums of high options plans for individuals up to 135% of poverty, 100% of premiums at or below 85% of the national average, and more where there is little or no competition.

b. Caps On Premiums: In areas where no competition to the government-run plan exists, beneficiary obligations for the premiums are capped at 12% of the government plan or the weighted national average, whichever is lower."

Rural Implications

"Rural Medicare beneficiaries, at least initially, will not benefit from the gains made through a competitive market. Instead, they will pay premiums that shift dollars from rural to urban areas. However, if the entire Medicare program is restructured to promote alternatives to the Government FFS plan, there may be ways to create provider panels and offer alternative plans at lower premium costs in rural areas."

"Rural beneficiaries are likely to pay a premium equivalent to a higher share of actual costs, as compared to urban beneficiaries, and perhaps higher than the current equivalent of Medicare Part B and Medigap coverage for deductibles and co-insurance. In reaching this judgement, the following assumptions are made:

a. In much of rural America, the Government FFS plan is likely to be the only plan available. There is currently little or no enrollment in managed care among rural Medicare beneficiaries, and under the Federal Employee Health Benefits Plan, the model for the premium support approach, the managed care plans offered tend to be limited to metropolitan areas.

b. The Government-run FFS plan will be using a single national premium, which means areas in which costs are below the average will generate revenues that transfer to expenses incurred in areas with above average costs.

c. Much of the variation around the average costs, especially if risk adjustment is used to factor in health status, will be similar to the historic differences that explained variation in capitation payment (adjusted average per capita cost, AAPCC).

d. The historic variation has been from low cost rural areas to high cost urban areas.

e. One might think other plans would then underbid the Government FFS plan in those areas where the FFS premium is higher than actual cost, but those are the same areas with low numbers of Medicare enrollees and are therefore not attractive to managed care plans.

f. The 12% cap on beneficiary premiums, then, is 12% of the national weighted average, which initially will be very close to the Government FFS plan."

Assessing the value of a competitive insurance market for rural Medicare beneficiaries

"The advocates of a premium support approach believe it would help contain Medicare expenditures, as well as offer greater choices to Medicare beneficiaries. The variation in plans would be in benefits offered (in addition to those currently included in Medicare) and in premiums charged. The federal employee health benefits plan (FEHBP) model upon which this approach is based, for example, includes 21 different plans in Nebraska. However, six of those are for particular groups of employees (such as secret service, rural carriers, foreign service), and the four managed care plans are offered in limited areas of the state (metropolitan areas)."

Rural Implications

"The most likely scenario is that most rural beneficiaries would still be selecting from a limited number of plans, or have no choice. This may change if health plans believe they can enroll sufficient numbers of Medicare beneficiaries to create a risk pool or if they believe Medicare beneficiaries can be added to an existing risk pool. Finally, rural providers may become involved in developing health plans if they see an advantage in taking a premium payment from Medicare rather than the payments from the Government-run FFS plan."

"In much of the nation, the promise of alternatives is not likely to have meaning for rural beneficiaries. This may change if there are general market conditions encouraging more development of alternative health plans in rural areas. Extension into Medicare business may

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.

Eye On Health Editor: Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583
(T) 608-643-2343 (F) 608-643-4936
Email: timsize@rwhc.com
Home page: www.rwhc.com

For a free email subscription of Eye On Health, write office@rwhc.com with "subscribe" on subject line.

be logical for health plans that are already active in the area. However, the Medicare population is not the same type of risk pool as are groups based on employment of the principal wage earner (such as the FEHBP model). Therefore, the responsiveness of health plans to new incentives in Medicare cannot be determined."

Assessing the impacts of a premium support approach on the rural health infrastructure

"The impacts of restructuring Medicare to a premium support plan would depend on the actions of health plans. Two sets of decisions will influence the impacts. First, plans will determine providers with whom they will work in providing access to services. Second, plans will determine payment to providers. Plans that rely on selecting provider panels as a means to be as cost-effective as possible may not even choose providers in rural areas, and may set boundaries of their service areas accordingly. The new Medicare Board will have the authority to approve plans and service areas, so presumably blatant discrimination will not be tolerated. However, not all rural Medicare beneficiaries would be in a position to take advantage of choices offered. There may not be providers in particular preferred provider plans in a location near the beneficiaries, as is true for plans participating in the FEHBP."

"The second decision plans would make is how to pay providers. They would be expected to employ the same means now used in competitive markets' discounts from usual charges, capitation, salary, and negotiated FFS. Plans would also, presumably, employ strategies of managed care including utilization management. The Government-run FFS plan is also encouraged to use market-based strategies in order to be competitive. This would be a change from current Medicare payment policies, but the impact on providers is uncertain. The current system in recent years has included sharp reductions in scheduled payment to providers, so any criticism of potential impacts would need to be compared to recent experiences, not to a base line that assumes Medicare FFS payment would be driven by provider charges. *Special payments (either cost-based reimbursement or bonus payments) are unlikely to continue for the following classes of providers: sole community hospitals, rural health clinics, physicians practicing in shortage areas, Medicare dependent hospitals, federally qualified health centers, and critical access hospitals."*
(Italics added by Eye On Health for emphasis.)

Rural Implications

"Advocates of the premium support approach should consider including requirements to pay full costs to essential rural providers, and requirements that health plans provide access to primary and emergency care throughout their service areas within reasonable distance of any beneficiary."

"Unless otherwise specified as protected categories in any legislation that implements the premium support approach, any special payment currently part of Medicare policy could be eliminated. The new policy would allow the Health Care Financing Administration (HCFA) to behave like any other insurer, employing 'modern' techniques of controlling expenditures that would not include paying any provider based solely on self-reported costs. The Government-run FFS plan is the only one in this approach that would pay all providers, based on treating Medicare beneficiaries. Other plans would be free to select only the providers they want for panels. While the current trend in the market seems to be that plans are more inclusive in selecting panels, there is no assurance that rural providers would be included in panels caring for Medicare beneficiaries. This combination of change in the Government-run program and the possibility of exclusive provider panels could jeopardize rural health."

Rural Hospital Plight Taken to the U.S. Senate

Anne Klawiter, Immediate Past President of RWHC and President/CEO, Southwest Health Center, testified in July before the U.S. Senate Appropriations Subcommittee on Agriculture and Rural Development on behalf of the Federation of American Health Systems. Her testimony described with laser accuracy the flaws in current Medicare policy regarding rural hospitals. An overview of her remarks is as follows:

"The Balanced Budget Act offers many challenges for all of us: Myself and my colleagues as providers, and you as Senators are faced with the tough decisions on how to best allocate our health care dollars. I personally am not afraid of challenge, nor of change. Over the past fifteen years, we have eliminated 85 acute care beds and consolidated hospital programs and services from three separate organizations encompassing three separate communities, into one location."

"However, I have some grave concerns regarding the opportunity, or lack thereof, for rural health providers to continue to offer quality patient care and services in light of reimbursement changes. In fact, due in large part to the cuts from the Balanced Budget Act, Southwest Health Center's operating margin for current programs will decline over a two-year period by 92%."

"The transfer provision of the Balanced Budget Act is creating serious problems, especially for rural hospitals that typically care for a larger percentage of Medicare patients. The transfer provision penalizes hospitals with shorter than national average lengths of stay, and undercuts the basic principle and objective of the Prospective Payment System for inpatient care. Therefore, the provision unnecessarily and unreasonably penalizes hospitals for effective, efficient treatment and for moving post-acute patients into the most appropriate setting to receive needed services and maintain quality of life. The transfer provision is reportedly having a

greater negative financial impact on hospitals than was originally estimated. I urge the Congress to act to repeal the transfer policy."

"Another area of significant concern is the proposed Medicare outpatient prospective payment system. The basics of the new payment system will reimburse hospitals for Medicare outpatient services according to ambulatory payment classifications (APCs) at established rates in a manner similar to inpatient DRGs."

"The Health Care Financing Administration has estimated that APCs will hit rural hospitals particularly hard, in part because rural hospitals are handicapped by lower volume, and have greater difficulty spreading losses to other areas. In short, small, rural hospitals with lower volumes are at a disadvantage. As a result, we may be forced to eliminate services that are unlikely to be provided elsewhere in the community, thus creating potential access problems."

"In addition, I understand that if HCFA's proposed outpatient rule remains unchanged, hospitals will be asked to shoulder an additional $900 million a year cut through a formula design that alters its budget neutrality intention. Seventy-seven Senators, including the majority of this committee, sent a letter to HCFA asking that the department reflect Congressional intent in its final rule and ensure that this additional hit to hospitals is not implemented."

"All hospitals are concerned with the fact that, under the BBA, the hospital market basket index, which is a proxy for hospital inflation or the cost of goods and services used, does not keep pace with inflation. Congress has the power to do many things, but it cannot control inflation. This is important because some 70 percent of our operating costs are labor-related. Particularly in rural areas, where labor markets are very tight and it is especially difficult to attract and retain adequately trained health professionals, Medicare payment updates must do a better job of recognizing the increasing costs of quality care."

"Southwest Health Center also operates a skilled nursing facility. Changes in the way nursing home care is reimbursed have created a significant administrative burden. The new prospective payment system for nursing home care and consolidated billing requirements has forced us to add at least one new administrative employee, just to administer the regulations. In fact, overload and ambiguity in Medicare regulations are an extreme burden for all healthcare entities."

"Recently, I had the privilege to participate in a study commissioned by the Wisconsin Department of Commerce and the Wisconsin Health and Education Facilities Authority. The study evaluated the importance of the healthcare sector on the economic well being of Grant County, where Southwest Health Center resides. It found:

- Every job lost in the healthcare industry causes a job to be lost in another local industry.

- Every $1 of revenue generated by the healthcare industry generates an additional $l.30 of revenue in other industries in the Grant County economy."

"Rural communities are often interwoven in this way. When there are changes to healthcare delivery they most certainly effect the quality and quantity of services available to local residents, and as this study underscores, these changes have serious economic implications for other industries in the county as well."

"Members of the Committee, you should also know that rural Wisconsin already receives 33% less per Medicare beneficiary than the national average. With the cost and advances in such important areas as technology and drugs, it is imperative that hospitals have the financial ability to keep current with state-of-the-art medicine."

"What do all of these changes mean for Southwest Health Center's ability to deliver quality patient care and contribute to the overall financial well-being of Grant County? With many BBA cuts yet to be implemented, coupled with the ever increasing salary and supply expenses, it seems highly unlikely that Southwest Health Center will be able to sustain delivering quality patient care. The impact of Medicare reimbursement is far reaching - and deserves careful examination."

"Thank you for the opportunity to share my experiences with you. I look forward to working with you to rebuild some of the Balanced Budget's damage to hospitals across the United States."

Today, we need you to write both of your U.S. Senators to support the Senate Rural Health Bill (S.980) and your U.S. Representative to support the House Rural Health Bill (H.R. 1344). You can get more information from the National Rural Health Association who has implemented a Rural Health Relief Action Plan; contact NRHA 202-232-6200 or <http://www.nrharural.org>.

Health Services Policy, Practice and Research: Making Connections

Keynote: William Roper, MD, MPH, Dean of the School of Public Health at the University of North Carolina.

November 4-5, 1999
Monona Terrace, Madison, WI

Sponsored by The Wisconsin Network for Health Policy Research

For info: 608-263-6294 or jaknutso@facstaff.wissc.edu

"Right" to be Elected Trumps Patients' Rights

From "Beyond the Bluster Over Health Care" by Michael M. Weinstein in *The New York Times,* 7/18/99:

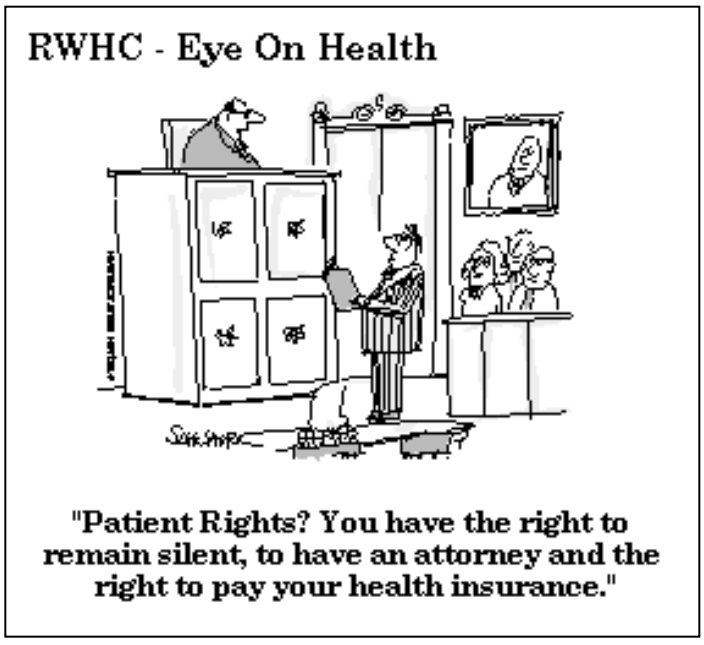
"After listening to the rancorous debate in the Senate over health care reform last week, it would seem obvious that differences between Democrats and Republicans are profound. The Democrats wanted to give powerful new Federal rights to patients in managed-care plans. The Republicans countered with narrower regulations."

"The debate consisted largely of name-calling. Vice President Al Gore labeled the Republican plan a 'charade' and Senator Tom Daschle, the minority leader, called it a fraud. Among the Republicans, Senator Phil Gramm of Texas accused the Democrats of deciding for political reasons 'to destroy H.M.O.s.' "

"But the partisanship obscures an important truth: The substantive differences are narrower than they seem. Removed from the context of election-year politics, combatants on both sides concede they could find ways to give Americans protection from health-care plans that wrongly skimp on coverage. 'These issues are eminently susceptible to compromise,' said Ronald F. Pollack, director of Families USA, a consumer advocacy group. 'It is a tragedy that this became a partisan dispute.' "

"Senate Democrats jousted with Republicans over rival legislation for a so-called patients' bill of rights. The Democrats' version would have given patients new rights to appeal a health plan's refusal to pay for tests or procedures, to sue health plans and to choose specialists in certain cases. On Thursday Senate Republicans passed a bill imposing less government regulation."

"Republicans know their bill will never get past President Clinton's veto pen. Many supporters of the Democrats' bill acknowledge privately that it overreaches and, besides, cannot pass. Never mind. Obstinacy serves a political purpose. Next year, Republicans will go fishing for campaign contributions from H.M.O.s and Democrats will do the same from trial lawyers."



Late BadgerCare Applicants May Lose Out

Phone Toll Free, 1-800-362-3002, for BadgerCare Enrollment Procedures and Assistance. BadgerCare is not an entitlement--individuals who delay applying may find that they face stricter income limits as the pool of available funds diminishes. For the same reasons, providers who encourage appropriate patients to sign up now will be better off than those who delay. The following was prepared by Bill Bazan, VP, Metro Milwaukee, Wisconsin Health and Hospital Association.

Eligibility

"BadgerCare is an expansion of Medicaid for parents and children under the age of 19, who do not have health insurance and have income at or below 185% of the federal poverty level (FPL). Once enrolled, the family can continue in the BadgerCare program until it goes over the 200% of the FPL. There is no asset test for BadgerCare."

Application

"BadgerCare will begin shortly. For those persons who already have a county caseworker because someone in the family is receiving Healthy Start, cash assistance, food stamps, W-2 benefits, or Medicaid, all they would need to do to enroll in BadgerCare is to contact their caseworker. The Department of Human and Family Services (DHFS) has developed a one page application form for easy enrollment in BadgerCare. If the person is already on the state's CARES system (Client Assistance for Reemployment and Economic Support) because they are in Healthy Start, receiving food stamps, etc., the application can be handled via telephone and the mail. For all others, they will need to see the county social service agency to enroll."

Premiums

"If family income is less than 150% of the FPL, they will not have to pay a premium to receive BadgerCare. If income is more than 150% of the FPL, they will have to pay a monthly premium of 3% of family income. The person has a choice of either paying the premium di-

rectly or through an automatic deduction from their pay check or bank account."

Employer Insurance

- "Families who can get health insurance through their job, cannot get BadgerCare if their employers pay at least 80% of the premium."

- "If the family has health insurance offered through their job and they do not take it, or had health insurance in the 3 months prior to application for BadgerCare (unless the reason the person lost the insurance was not due to his/her own fault), they are not eligible for BadgerCare, even if the employer does not pay the premium. However, if the employer does not pay at least 80% of the premium, the person can drop the insurance, wait 3 months, and then apply for BadgerCare."

Benefit of BadgerCare to Farm Families: BadgerCare will assure access to health care for all low-income families who do not have employer insurance, including farm families. By extending eligibility to higher income levels and **by eliminating the asset test**, farm families with children will be more likely to qualify for BadgerCare. BadgerCare will provide health care to farming families with income less than 185% of the federal poverty level (FPL) and without access to affordable health care.

Benefits

"BadgerCare will cover all the services covered by Wisconsin's Medicaid program such as doctor's visits, hospitalizations, prescription medicines, psychiatric care, dental care, etc."

Local Teenage Actors Reaching Other Teens

Wisconsin Rural Partners, Inc. is sponsoring a rural health and arts project entitled *Windows of Opportunity* aimed at developing community-based approaches to teen and adolescent health and social issues. As described by their Director, Kelly Haverkampf:

"The project uses performance art and community interaction to deliver positive messages and resources for assistance to teens and adolescents. The project is a collaboration between local schools, arts agencies, health organizations and agencies, law enforcement, faith-based institutions, and parent organizations, among others."

"A survey conducted by Wisconsin Rural Partners in 1998 provided the impetus for the development of a statewide program which brings together the talents of arts groups and resources of health organizations to initiate a public dialogue on issues such as peer pressure, pregnancy, alcohol and drug abuse, suicide, physical and mental abuse, among others. A Wisconsin Rural Partners task group worked throughout 1998 to develop a strategy to implement the project, which includes a demonstration project in a rural Wisconsin community."

"Wisconsin Rural Partners, Inc., will sponsor a demonstration project of *Windows of Opportunity* for the school district around Blanchardville for 1999, while the organization raises funds to promote use of the project in other rural communities throughout Wisconsin. The Partnership will evaluate and refine the programming during early 2000, and project will be offered to other communities later in the year."

"Contributions to the *Windows of Opportunity* initiative are encouraged and appreciated - the amount of funds raised for the project in the next year will determine the number of communities to which the program is offered following the demonstration project. Tax-deductible contributions can be sent to Wisconsin Rural Partners, Inc., P.O. Box 257, Lodi, WI 53555. More information can be obtained from Kelly Haverkampf at 608-265-4525.

Statewide Satellite Dialogue to Help Kids

Apple Pie In Action (perhaps unfortunately, no relation to the new teen film, *American Pie*) is co-sponsored by the Maternal and Child Health Education and Training Institute, WI Area Health Education System and the University of Wisconsin Medical School and with support from the WI Department of Health and Family Service.

On September 28th, from 11:30 am through 1:15 pm, a broad array of people from parents to educators, from law enforcement to youth leaders will meet across the state via satellite.

"All around us are examples of what's possible and worth doing, right here where we live, learn, work and play. Research now shows us clearly what kids need to survive the challenges of growing up, and to thrive. Parents can't just leave it to the schools, professionals, youth programs and law enforcement. And everyone else just can't say 'it's the parents' job.' For healthy, caring and responsible youth, we can help each other and work together."

"This discussion is more than a quick overview of asset-building approaches. It's about communities coming together to prevent problems instead of waiting for them to happen--practical things we can do as individuals, families, neighborhoods--as private citizens working with schools and local governments to make things happen."

1. "Learn about new funding and resources; how to get help.

2. Practical, specific ways to apply the asset-building approach--tips, checklists, ideas and support.

3. Next steps, from needs assessment to action."

To participate, contact the Health Promotion Project, 608-265-4079 or <www.dcs.wisc.edu/pda/applepie>.

Spirituality, Medicine & Advocacy

This article says something about how the author approaches his work as a health care advocate--*Spirituality Is to Medicine as Spinach Is to Popeye* by Bill Bazan, Wisconsin Health and Hospital Association.

"My grandmother once told me years ago during a rather difficult and depressing time of my life: 'Billy, remember this, and never forget – age may wrinkle your face, but lack of enthusiasm will wrinkle your soul!' With wisdom that comes from a long life and reflecting on experiences, grandma also taught me that I am born with a spiritual center, at the very heart of who I am. That spiritual center, my soul, was created to impel me towards happiness, deeper meaning, and a sense of wholeness in life. 'When life gets tough, when you feel that you are losing control, remember the power that is at the center of who you are – hold your life still enough to listen to what is within you. In moments of distress, that is what will come out. Squeeze an orange and out comes orange juice. What comes out when you are squeezed?' she often would say."

Some spiritual learnings for along the way…..

"My mind has the capacity to twist reality to conform to my beliefs about the way life I think should be, not accepting life's experiences as they are and as they unfold. A wonderful example of this kind of thinking (or rationalizing) was uttered by comedian George Carlin: 'I am not a *complete* vegetarian. I eat only animals that have died in their sleep!' My mind can project meaning into any experience. This projection – coming out of my own mind set – can color reality to fit me. People who are control addicts do this all the time. On the other end of the spectrum are the people who accept reality as it is and hold their life still enough, accessing their own inner power as they prepare to respond to experiences. For these people, experiences become their best teachers. They ask the question: 'What is this experience trying to teach me?' Powerful people, coming from the 'juice' inside, respond creatively, and with energy to the demands of their situation."

"My capacity to change, to make sense out of the situations that my life is presented with, is in direct proportion to my capacity to stay connected to the power, energy and enthusiasm that are part and parcel of who I am in the depths of my own inner spirit. The startling paradox is this: when I truly accept myself as I am, and begin to have a sense of ownership of the power at my very core, the less likely it will be that I surrender that power to others or give in to the challenges of my personal and/or professional life. Perhaps one of the ways I surrender my power is by allowing myself to stay depressed, distressed and in a blaming mode? That is literally what happens when I lose sight of who I really am inside. To stand in my own power and to act from it is to view the challenges that are presented to me daily, not as threats, but as opportunities and teachers for new life and growth."

"I give power to what I pay attention to. My grandmother should have been a Hallmark greeting card writer. I asked her what religion meant in her life. She thought for a moment, took a sip of wine, her eyes beaming and said: 'I'm 89 years old, a couple of sandwiches short of a picnic in my old age, and a Christian Scientist. My religious tradition is meant to serve my spirituality, not the other way around. Let me put it this way: religion is meant for those afraid of hell, spirituality is for those who have been there! The only reason I go to church and pray is because my church helps me to see that it is not an end in itself, but a means to an end.' She added quietly, 'I love God. It has taken me almost 90 years, but He has found me. I never realized He was so close!' I give power to what I pay attention to. The choices are mine."

Ethics Consultation for Rural Providers

After 8 years as Nurse Consultant with RWHC, Linda Briggs has taken a position as an Ethics Consultant with Gundersen Lutheran Hospital in LaCrosse, working with Dr. Bud Hammes, well known clinical ethicist. Her major areas of responsibility will be developing a national curriculum and training program for the LaCrosse *Respecting Your Choices* end-of-life care planning program, presenting ethics educational programs nationally and statewide, and providing ethics consultation to statewide ethics committees and other interested parties.

To this end, Linda will continue to provide ethics consultation to RWHC and will continue to facilitate RWHC's Ethics Roundtable. Linda has facilitated the growth and development of three RWHC member organizations' ethics committee education, policy recommendations, case consultation and meeting mechanics. This service has demonstrated significant improvement and satisfaction in the work these small rural ethics committees have been able to do. Linda has agreed to continue this service to these RWHC organizations in her new position. For the immediate future, Linda can be reached through RWHC and she welcomes further requests for ethics consultation.

Women-Ask Questions & Live Healthier

The following is from a bookmark being distributed by the Wisconsin's Women's Health Foundation; for more information they can be reached at 44 East Mifflin Street, Suite 201, Madison, WI 53703 or at 608-251-1675 or <wihealth@chorus.net>.

"If you're 20, 50, 70 or in between... Ask your health professional these questions and live well:

1. Do I need to have a mammogram? When? How often? Or if not, why not?

2. How often should I do a breast self-exam?

3. Is it time for hormone replacement therapy? How will I know?

4. How often should I have my blood pressure checked?

5. Can you provide me with diet/nutrition advice?

6. Should I be checked for osteoporosis? Perhaps a bone density test? If not, why not?

7. How do I prevent (or treat) osteoporosis?

8. How much calcium is right for me? What is the best way for me to obtain this calcium?

9. Should I exercise? What kind? How often?

10. What are the first signs of menopause?

11. How often should I have a pelvic exam and pap smear?

12. Should I have my cholesterol level checked?

13. How often should my thyroid levels be checked?

14. Should I get any regular vaccinations now that I am an adult?

15. Should I be screened for colon cancer?

16. How can you help me stop smoking?

17. Is my emotional state affecting my physical health? If so, what do you recommend?

18. How do I find help if I am being battered?"

A Snap Shot of Rural History/Future

From an excellent white paper by the Tiber Group, *New Rules, New Roles for Rural Healthcare Providers…;* available from 312-609-9900 or at www.tiber.com:

1940's "Bring Hospitals to Every Community"
1950's "Bring Insurance to Hospital Patients"
1960's "Pay for the Elderly and the Poor"
1970's "Bring in Physicians/Money to Meet Demand"
1980's "Bring in the Controls"
1990's "Rein in Costs; Bring in Competition"

Use BlueCross Monies Off Campus, Over Time

Like everyone in this year's mega food fight, we at RWHC have also weighed in on how the BlueCross Foundation monies for public health should best be managed; our focus is on process and is as follows:

- Each of the medical schools receiving the BlueCross conversion dollars should create a Public Health Fund and spend just the earnings in order to (a) maximize a more deliberative process and (b) serve as a base to attract other investments/donations.
- Distribute a majority of the funds available each year to community-based organizations and coalitions through a competitive process with a jury selected from a cross-section of individuals representing interests from both on and off the campus.