



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

Enough Already, Feds Approve BadgerCare

The first part of this item is from a press release by Wisconsin's Governor Tommy Thompson, 1/22/99:

"Wisconsin and the Clinton administration have reached agreement on the major waiver provisions for BadgerCare, which will help provide affordable health coverage for 46,000 adults and children in low-income working families. BadgerCare is a new health insurance program designed to fill the gaps between Medicaid and private insurance by providing Medicaid coverage to children and adults in uninsured families with income below 185 percent of the federal poverty level. It is projected to provide health care to an additional 46,200 low-income Wisconsin residents, including 23,900 uninsured children and 22,300 parents."

"Under the federal waiver, BadgerCare will expand Medicaid coverage for families using a blend of Title XIX (Medicaid) and Title XXI (Child Health Insurance Program). BadgerCare will fund children's health care costs and families who qualify for employer-sponsored coverage through Wisconsin's Title XXI allocation, other parents will be funded through Title XIX. Wisconsin's original waiver request assumed that all BadgerCare enrollees would be funded under Title XXI, which carries a higher federal matching rate than traditional Medicaid."

"Gov. Thompson noted that under BadgerCare, families with income at and below 150 percent of the federal poverty level will be exempt from cost-sharing. For families earning more than 150 percent, BadgerCare will require a monthly premium of 3.5 percent of family income."

"BadgerCare's annual cost is projected at \$71.3 million, of which \$44.6 million is federal, \$21.3 million is State, and \$5.4 million is premium revenue. The service delivery system for BadgerCare is built on Wisconsin's existing Medicaid HMO managed care program, including provisions for quality assurance and improved health outcomes."

"The governor noted that, if BadgerCare enrollment is projected to exceed budgeted enrollment levels, a

new enrollment eligibility threshold will be established for new applicants."

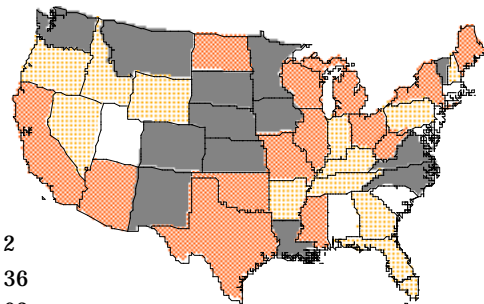
Organizations and individuals around Wisconsin joined the State in lobbying hard for BadgerCare. One of the best cases was stated by Greg Nycz, Director of Marshfield's Family Health Center, an excerpt follows:

Programmatic Issues

"Let me begin by stating that I am not at all confused about the clear legislative intent in using Title XXI funding to support services to low-income, uninsured children. The demand for financial assistance for low-income individuals from our small part of the State of Wisconsin exceeds our capacity to serve by over 120%. We have a waiting list for our program that includes over 7,000 low-income individuals who have come to us for assistance through word of mouth and multiple referral sources."

"Congress and our state legislature have recognized and addressed this burden on a national and state

Rural Providers Approved For Internet Discounts



- 0 - 12
- 13 - 36
- 37 - 63
- 64 - 224

Approved as of 1/4/99

Data: FCC, 1/99

Graph: RWHC, 1/99

On December 31, 1998, the Federal Communication Commission extended the Rural Health Care Corporation's (RHCC) first funding year to June 30, 1999. Applications previously submitted are valid through June 30, 1999, and first year applications continue to be accepted. The RHCC and the Schools and Libraries Corporation merged with the Universal Service Administrative Company (USAC) on January 1, 1999. RHCC is now the Rural Health Care division of USAC. For more information, call 202/776-0200 or go to <www.rhccfund.org>.

level by allocating financial resources to provide assistance but the federal executive branch has determined that there is no legal way to implement the program as proposed given statutory constraints.”

“I believe there is no debate, that while providing health care coverage for children is better than leaving them uninsured, it is not as good as addressing the health care coverage needs of the entire family. If there is agreement on this, we should set, as a long-term goal, the achievement of universal access. Something the administration is clearly on record of supporting.”

“Given the decision to prioritize coverage of children first, we must deal with barriers to enrollment. To understand these barriers we must first understand that for many we are increasing the complexity of the health care financing system and are bringing a level of arrogance to the table by telling families we know what's best for them when many perceive their children to be healthy and not needing health care, but mom or dad have a serious health problem that threatens the economic viability of the family or adds emotional stress to daily family interactions. It is these families who tell us we don't get it.”

“It is an unfortunate reality that in spite of one-on-one direct counseling; we won't pick these children up with a child only program. BadgerCare, as designed, will not only pick up these children as part of the family, it will also help with the emotional strain on families whose health care needs center around mom or dad.”

“Wisconsin offers an ideal site to try a family-centered approach to maximizing coverage of children because it has one of the lowest uninsured rates in the country. I believe there is an excellent chance that more children could be covered with Title XXI funds in the State of Wisconsin if we were given an opportunity to demon-

strate the value of addressing the family's needs as an approach to maximizing the participation of children in the program. Results of a research waiver in Wisconsin might help to propel the country to consider this family-centered approach in future allocations of resources.”

Political Issues

“Why would Democrats pressure a Democratic administration to grant a Republican Governor a waiver to more comprehensively help the people in this state? The short answer is because it's the right thing to do for the people we care about. Another answer is if given the choice to petition a Democratic Administration or a Republican Legislature for authority or resources to move forward, I would have hoped my best chances would lie with the Democratic Administration.”

“A final point is also worth noting. In north central Wisconsin regional acquisitions and mergers have heightened competition in the medical market polarizing competing entities. In this dynamic polarized and competitive environment, providers are agreeing to rise above their daily competitive skirmishes to collaborate with their competitors on a real time, electronic immunization registry to improve immunization rates for the good of our children. Providing the best health care to the people of this country should not be a partisan issue and we should be open to good ideas irrespective of their point of origin. BadgerCare is a good idea.”

One of the unknowns about BadgerCare faces is whether a greater than anticipated number of employees of small employers will end up losing employer based health insurance and applying for BadgerCare. Reform of the small business health insurance market as described later in this newsletter would address part of this risk.

Drug Companies & Elderly Face-off on Medicare

From “Clinton's Plan to Have Medicare Cover Drugs Mean a Big Debate Ahead in Congress” by Robert Pear in *The New York Times*, 1/24/99:

“President Clinton is proposing a major expansion of Medicare to cover prescription drugs, a change long sought by older Americans, and a federal advisory commission may soon endorse the idea.”

“But drug companies are gearing up to fight any plan for the government to provide prescription drugs as a basic benefit in the traditional Medicare program. They fear that it would lead to federal regulation of drug prices, which is anathema to the industry.”

“Republicans agree that there is a need to help the elderly with drug expenses, though they tend to favor more modest plans.”

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 furthers the development of a coordinated system of rural health care which provides both quality and efficient care in that best meet the needs of rural residents in a manner consistent with their community values.

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“For many elderly people, drug costs are a heavy burden. Spending on prescription drugs has increased at a brisk pace, not so much because the prices of older drugs are rising as because people are using more drugs, and some new, highly effective medications have high prices -- \$10,000 a year or more. The Food and Drug Administration is approving more drugs, and doctors say that many of the new products are clearly superior to the old ones.”

“The cost of Medicare prescription-drug coverage would depend on the generosity of the benefit and other factors, but even the strongest proponents admit that it would be expensive. The Medicare commission is studying several options. A relatively modest drug benefit would cost the government \$10 billion to \$15 billion a year, it said, and could add \$9 or \$10 to the monthly Medicare premium, now \$45.50, which is deducted from a person's Social Security check.”

“Medicare generally does not pay for drugs used by patients outside the hospital. But Medicare officials said that 80 percent of beneficiaries regularly used prescription drugs, reflecting the high incidence of chronic illnesses among the elderly.”

“A new government study says that 65 percent of Medicare beneficiaries have supplemental insurance to help pay drug costs, while 35 percent have no such coverage. Premiums for private insurance covering prescription drugs are often high, and there is no guarantee that the people who need coverage can get it.”

“If the government created a Medicare drug benefit, it would become acutely concerned about drug costs. Drug companies insist that the government must not establish a list of approved drugs for Medicare beneficiaries or a uniform national price list. On the other hand, administration officials and congressional Democrats say Medicare ought to get substantial discounts because it would be one of the nation's biggest purchasers of drugs.”

“Private insurers often follow Medicare's payment policies, and that possibility worries drug companies. ‘Seniors account for one-third of the market,’ said Holmer, the president of the pharmaceutical association. ‘Any practices that would affect such a large proportion of patients become trend setters for all health plans, for better or for worse.’ ”

Medicare's Management Crisis Hurts Us All

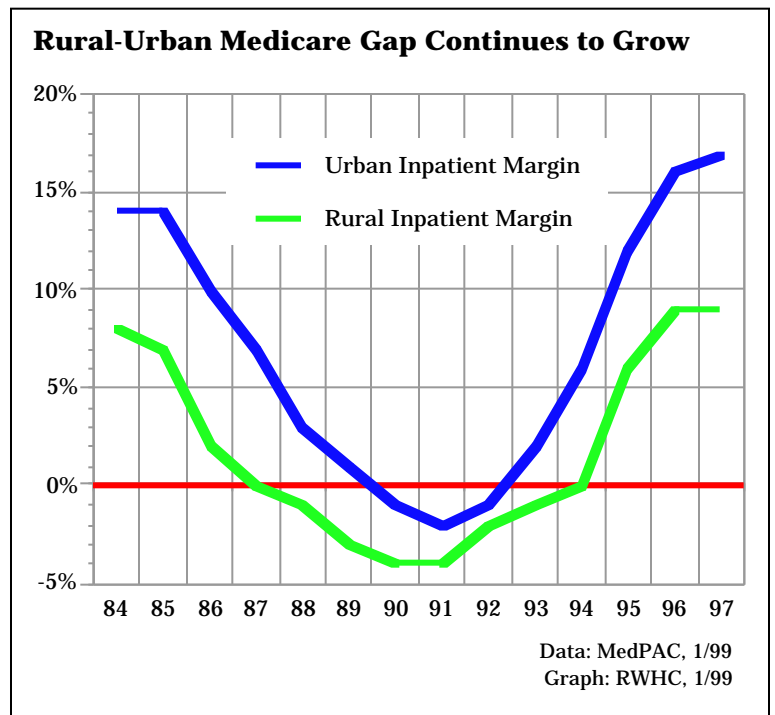
Rural interests have long been frustrated and harmed by the “one-size-fits-all” Medicare management style of the Health Care Financing Administration (HCFA). Time after time, that one size is a poor fit for rural communities and providers.

An example of this style and its negative effect on rural health is the ongoing failure of HCFA to develop an alternative to the simplistic and technically flawed hospital wage index. Anti-rural biases along with a lack of understanding contribute significantly to this problem but so does the more basic failure of the federal government to provide the necessary resources and flexibility that any well managed business or program requires.

The Medicare management crisis is the theme of “Crisis Facing HCFA & Millions of America,” an “open letter” from a cross-section of some of the country's most respected health policy analysts, Uwe Reinhardt, Gail Wilensky and William Roper to name a few; published in *Health Affairs*, 2/99; a portion of that letter follows:

“The signatories to this statement believe that many of the difficulties that threaten to cripple HCFA stem from an unwillingness of both Congress and the Clinton administration to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment. This is not a partisan issue, because both Democrats and Republicans are culpable for the failure to equip HCFA with the human and financial resources it needs to address what threatens to become a management crisis for the agency and thus for millions of Americans who rely on it.”

“Over the past decade Congress has directed the agency to implement, administer, and regulate an increasing number of programs that derive from highly complex legislation. While vast new responsibilities have been added to its heavy workload, some of its most capable administrative talent has departed or retired; other employees have been reassigned as a con-



sequence of reductions in force. At the same time, neither Democratic nor Republican administrations have requested administrative budgets of a size that were commensurate with HCFA's growing challenge."

"The mismatch between the agency's administrative capacity and its political mandate has grown enormously over the 1990s. As the number of beneficiaries, claims, and participating provider organizations; quality and utilization review; and oversight responsibilities have increased geometrically, HCFA has been downsized... The sheer technical complexity of its new policy directives is mind-boggling and requires a new generation of employees with the requisite skills."

"Medicare spending accounts for more than 11 percent of the U.S. budget. Workable, effective administration has to be a primary consideration in any restructuring proposal. Whether Medicare reform centers on improving the current system, designing a system that relies on market forces to promote efficiency through competition, or moving toward an even more individualized approach to paying for health insurance, Congress and the administration must reexamine the organization, funding, management, and oversight of the Medicare program. Doing anything less is short-changing the public and leaving HCFA in a state of disrepair."

Market Questions For-Profit Managed Care

From "For Managed Care, Free-Market Shock" by Reed Abelson in *The New York Times*, 1/3/99:

"The last few years have proved enormously difficult for many of the businesses created to capture the vast sums flowing through the nation's health-care system -- now more than \$1 trillion each year. In particular, companies designed to oversee the delivery of care, like HMOs and groups of doctors' practices, are struggling."

"Offering some discipline and an entrepreneurial approach, these enterprises had promised to deliver health care much more efficiently than some of the traditional players like Blue Cross and Blue Shield plans -- many of which are nonprofit -- or independently functioning doctors. Investors would share in the savings, they claimed, and the public would benefit from a respite from the relentless climb in health-care costs."

"But a real debate is emerging over whether these businesses can wring more efficiencies out of the system and therefore make money over the long haul. While they prospered by taking advantage of easy one-time savings, like the use of their clout to get doctors and hospitals to accept less to provide care, their fat profits could prove ephemeral in the face of medical costs that they, too, cannot control."

" 'In the short term you can make money,' said Howard Berliner, chair of health services and management policy at the New School for Social Research in New York. 'In the long term, you can't.' "

" Having rejected costly old-style medical insurance and Clinton administration proposals for government-supervised health care, the nation has embraced profit-making managed care companies as the solution to rising medical costs. The failure of these companies to work out their problems is more than just bad news for investors; it raises doubts about the theory that managed care, left to the forces of the free market, would, within a few years, distribute resources effectively and keep costs down."

"While many of the managed-care companies were able to significantly raise their premiums for 1999, they may never be as profitable as they were five years ago. And the public's willingness to accept higher prices may be short-lived if people begin to believe that there is not enough money to go around to insure that care remains affordable."

" 'The cold reality began to dawn on people in the system: Saving money for employers and making money comes at the expense of public access to doctors, hospitals and services,' said Dr. Arnold Relman, a former editor-in-chief of the *New England Journal of Medicine*."

"Critics of the current system say it has never offered an economic incentive to care for sick people. Because the insurers do not spread the risk of caring for the sick over the entire population, and are not paid more when they provide more care, the companies can only thrive by covering those who are healthiest."

" 'Unless you have a health-care system designed to encourage health plans to treat the sick, and not compete purely on cost, there will be no winners,' said Diane Archer, executive director of the Medicare Rights Center, a New York consumer group."

"Others doubt whether the businesses will ever succeed, especially if they attempt to provide care for every one, including those who cannot afford it. 'If I were a Wall Street analyst,' said Relman. 'I would have a no-buy recommendation on them all.' "

HMOs Match Traditional Insurance Increases

From a Towers Perrin Press Release, 1/6/99:

"For many large employers, 1999 will bring the first significant jump in employee and retiree health care costs since the early part of the decade, according to the latest annual Towers Perrin Health Care Cost Survey. The survey found that the cost of large employers' health benefit plans will increase about 7% on average

in 1999, almost twice as fast as the 4% average increase reported in 1998. The last year in which participating employers reported cost increases averaging above 5% was 1994, when costs rose 6%.”

“Perhaps most significant, the survey shows that the cost of health maintenance organizations (HMOs) will grow as fast or faster on average in 1999 than the cost of traditional indemnity medical plans,” said William J. Falk, a principal in Towers Perrin’s Chicago office and the firm’s director of actuarial practice for health and welfare. ‘In recent years, managed care costs have grown more slowly than indemnity plan costs, enabling employers to control cost growth simply by offering managed care to their employees and retirees. Our findings suggest that the easy savings offered by managed care may already be behind us.’”

“This year’s increase in health care costs is substantially above the U. S. inflation rate, which economists estimate rose only about 1.5% in 1998, as measured by the government’s Consumer Price Index.”

“In 1999, many managed care plans appear to be trying to recoup their past losses, rebuild profits and expand market share through acquisitions,” Falk added. ‘Moreover, we’re seeing unusually sharp increases in prescription drug costs and a health care market that continues to experience rising demand for services from an aging population.’”

“This survey was conducted in November. Participants were asked to report their 1998 and 1999 per capita premium costs for insured health and dental plans, and premium equivalents (i.e., estimated benefit and administrative costs) for self-insured plans. A total of 213 employers, primarily large Fortune 1000 companies with operations in numerous locations nationwide, responded to the survey. The participating companies provide medical benefits to more than 3.1 million employees, retirees and dependents across the country.”

Does Wisconsin Intend to Hurt Small Business?

There is no argument that small businesses are at a significant disadvantage when they try to access health insurance for their employees. However, we in Wisconsin have stumbled time after time in attempting to do much about it. Our failure would be less embarrassing if other states hadn’t made significant progress.

This year’s debate has been kicked off with the introduction of *1999 Senate Bill 1* has been introduced in order to create a state administered health care coverage plan for employers in the private sector.

According to an analysis by the Legislative Reference Bureau, the bill requires the Department of Employee Trust Funds (DETF), after consulting with the De-

Average 1999 Monthly Health Care Costs and Cost Increases by Type of Plan

	Employee Only	Employee Plus Spouse	Family	Average Increase from 1998
Indemnity	\$200	\$396	\$529	8%
PPOs	\$178	\$374	\$514	4%
POS	\$171	\$349	\$483	5%
HMOs	\$161	\$328	\$459	8%

Data: Towers Perrin, 1/99
Graph: RWHC, 1/99

partments of Commerce and Health and Family Services and the Office of the Commissioner of Insurance, to design, establish and administer a health care coverage plan for employers in the private sector. The bill also creates a private employer health care coverage board (PEHCCB) that is responsible for approving the health care coverage plan before DETF may implement the plan.

The key features of the private employer health care coverage plan are as follows:

1. Any employer in the private sector that employs two or more employees is eligible to participate in the plan.
2. Any employer that participates in the plan must offer the health care coverage to all of its permanent employees who have a normal work week of 30 or more hours and may offer the coverage to any of its other employees.
3. Any employer that participates in the plan must provide health care coverage under the plan to at least 50% (or a higher percentage specified by the PEHCCB) of its permanent employees who have a normal work week of 30 or more hours.
4. Any employer that participates must pay, on behalf of each employee who has coverage, at least 50% but not more than 100% of the lowest premium that would be available to the employer for the coverage.
5. Any employer that participates in the plan and that voluntarily terminates the coverage must wait at least three years before the employer may participate again.
6. Any insurer that offers the plan must provide coverage under the plan to any employer that applies for coverage, without regard to the health condition or claims experience of any individual who would have coverage, as long as the employer pays the premium and agrees to comply with plan requirements.

7. The health care coverage plan is subject to all provisions of the state insurance code to the same extent as any other group health benefit plan that is offered in the private sector.
8. The plan may not be combined with any health care coverage plan offered by DETF to state employees.
9. The plan may only be sold by licensed insurance agents in this state.

RWHC's New Office Now a Reality

The new RWHC address is now in effect, please note the following:

**880 Independence Lane
P.O. Box 490
Sauk City, WI 53583**

Phone, fax, email and web addresses are unchanged. A map to the new office was in the January newsletter and can be accessed at <www.rwhc.com>.

In addition to the RWHC board, particular thanks are due to Pat Ruff, RWHC Deputy Director, for her advocacy that the time and opportunity had arrived for the Cooperative to build a proper office as well as her follow through with the total management of the project. While all staff have put in extra time participating in planning the building and the move into it, special thanks are due to Darrell Statz for his coordination of the project, Rich Donkle for his assistance with the financial aspects and Monica Seiler for her help with all the operational components.

For the Cooperative, this is a time to celebrate, to say thanks and to look ahead as we:

- move into our first coop owned building on Feb. 4th,
- approach our 20th anniversary this summer,
- continue as a stable point in a chaotic "business,"
- demonstrate that the cooperative model works and
- are well positioned for 20 more years of innovation.



RWHC, 880 Independence Lane, Sauk City, Wisconsin

WI Coalition for Health Insurance Reform

The Wisconsin Coalition for Health Insurance Reform is comprised of farmers, small businesses, health care providers, associations and cooperatives who have joined together with the goal of finding a means for small businesses and individuals to access health insurance with premiums and premium predictability closer to that of larger businesses.

After over a year of preparation, the Coalition held its first of four invitational working sessions with insurers and legislators to develop a collaborative strategy.

Kevin Haugh from the Washington based Health Policy Solutions is providing the participants with neutral technical expertise. He repeatedly noted that there are no villains regarding the current market place--that everyone (barring the occasional illegal player) is operating by the rules of the current system. "If you don't like the results you need to change the incentives." He also emphasized that every alternative has both its advantages and disadvantages, that the fundamental decisions are around which tradeoffs you want to make.

The coalition's work is facilitated by Wisconsin Rural Partners. For this phase they are using a "collaborative learning model" which emphasizes *situation* rather than *conflict*, *improvement* rather than *resolution*, *interest* rather than *positions* and *feasible change* rather than *desired future*.

For more information contact Kelly Haverkamp at Wisconsin Rural Partners, Inc., (608) 592-2550.

Physician Practice Styles Effect Health Status

From "Physician Practice Style Affects Patient Outcomes And Satisfaction," in the federal Agency for Health Care Policy & Research newsletter, *Research Activities*, 11/98:

"Family physicians tend to have a practice style that emphasizes health behavior (for example, discussion of nutrition and exercise), counseling, and personal conversation, whereas internists tend to use a more technical style. Internists are likely to confine the office visit to details related to the current complaint or prior illness, medical history, physical examination, lab work results, and the medication or treatment plan. However, it is the physician's behavior, not specialty per se, that affects patient satisfaction and outcomes, finds a study supported by the Agency for Health Care Policy and Research (HSO6167)."

"The study found that patients of physicians whose practice style emphasized the psychosocial aspects of

care were more likely to report better health status. Also, patients of doctors who encouraged them to discuss health information and ask questions (patient activation) and who chatted with them about personal topics were more apt to report satisfaction with their care, notes Klea D. Bertakis, M.D., M.P.H., of the University of California, Davis. Dr. Bertakis and her colleagues randomly assigned 509 patients at a university medical center to a family practice or internal medicine clinic at the center and followed them for 1 year of care. They observed patient-physician interactions during office visits and administered the health status and patient satisfaction questionnaires."

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Beyond Experts, Stories That Heal

From the introduction of a book of stories, *Kitchen Table Wisdom, Stories That Heal* by Rachel Naomi Remen, M.D., medical director of the Commonweal Cancer Help Program in Bolinas, California:

"When we haven't the time to listen to each other's stories we seek out experts to tell us how to live. The less time we spend together at the kitchen table, the more how-to-books appear in the stores and on our bookshelves. But reading such books is a very different thing than listening to someone's lived experience. Because we may have forgotten how to listen, stopped learning how to recognize meaning and fill ourselves from the ordinary events of our lives. We have become solitary; readers and watchers rather than sharers and participants."

"All stories are full of bias and uniqueness; they mix fact with meaning. This is the root of their power. Stories allow us to see something familiar with new eyes. We become in that moment a guest in someone else's life, and together with them sit at the feet of their teacher. The meaning we may draw from someone's story may be different from the meaning they themselves have drawn. No matter. Facts bring us to knowledge, but stories lead to wisdom."

"After thirty-five years of being a physician and more than forty years of living with my own life-threatening illness, I too am a woman who is full of stories. Stories I have lived and stories I have been told... If I were sitting at your kitchen table the way a family physician used to do, these are some stories I would bring with me."

Today's Organizations Require New Skills

From "The Necessary Art of Persuasion" by Jay A. Conger in the *Health Forum Journal*, 2/99:

"If there ever was a time for business people to learn the fine art of persuasion, it is now. Gone are the command-and-control days of executives managing by decree. Today businesses are run largely by cross-functional teams of peers and populated by baby boomers and their Generation X off-spring, who show little tolerance for unquestioned authority. Electronic communication and globalization have further eroded the traditional hierarchy, as ideas and people flow more freely than ever around organizations and as decisions get made closer to the markets. These fundamental changes more than a decade in the making but now firmly part of the economic landscape, essentially come down to this: work today gets done in an environment where people don't just ask What should I do? but Why should I do it?"

"Establish credibility. The first hurdle persuaders must overcome is their own credibility. A persuader can't advocate a new or contrarian position without having people wonder, Can we trust this individual's perspectives and opinions? Such a reaction is understandable. After all, allowing oneself to be persuaded is risky, because any new initiative demands a commitment of time and resources. Yet even though persuaders must have high credibility, our research strongly suggests that most managers overestimate their own credibility - considerably."

"Frame for common ground. Even if your credibility is high, your position must still appeal strongly to the people you are trying to persuade. Effective persuaders must be adept at describing their positions in terms that illuminate their advantages. As any parent can tell you, the fastest way to get a child to come along willingly on a trip to the grocery store is to point out that there are lollipops by the cash register. That is not deception. It is just a persuasive way of framing the benefits of taking such a journey. In work situations, persuasive framing is obviously more complex, but the underlying principle is the same. It is a process of identifying shared benefits."

"Provide evidence. With credibility established and a common frame identified, persuasion becomes a matter of presenting evidence. Ordinary evidence, however, won't do. We have found that the most effective persuaders use language in a particular way. They supplement numerical data with examples, stories, metaphors, and analogies to make their positions come alive. That use of language paints a vivid word picture and, in doing so, lends a compelling and tangible quality to the persuader's point of view."

“Connect emotionally. In the business world, we like to think that our colleagues use reason to make their decisions, yet if we scratch below the surface we will always find emotions at play. Good persuaders are aware of the primacy of emotions and are responsive to them in two important ways. First, they show their own emotional commitment to the position they are advocating. Such expression is a delicate matter. If you act too emotional, people may doubt your clearheadedness. But you must also show that your commitment to a goal is not just in your mind but in your heart and gut as well. Without this demonstration of feeling, people may wonder if you actually believe in the position you're championing.”

Touchy Feely or Pragmatic Management?

From a review of Max De Pree's "Leading Without Power: Finding Hope in Serving Community" by Anita Manuel (1/98) on the web site BookWire <www.bookwire.com>. BookWire is "the book industry's most comprehensive and thorough online information source."

"A member of *Fortune* magazine's National Business Hall of fame and author of the best selling *Leadership Is An Art* and *Leadership Jazz*, De Pree has written another fine little book with lots of space between the lines and in the margins for taking notes and personalizing. His audience is the many people in business who could profit from understanding and practicing the virtues and policies of the million-and-a-half not-for-profit organizations in this country. His goal is to help each of these people 'move personally and organizationally from mastery to joy' while 'creating places of realized potential.' It's a different kind of bottom line, a much more humane one. De Pree draws from a deep well of

experience to provide wise chapters on measurement ('Measure what is significant rather than what is easy to measure'), on the roots of service learned in the family, on the attributes of vital organizations, on risk and hope and moral purpose. An inspiring book."

In Max De Pree's words: "Then there are other, exceptional organizations that we can more precisely call movements... Movements are easier to recognize from the inside. There is harmony in relationships and a constructive conflict of ideas. There is palpable unity as the people there implement their vision. There is a rhythm of innovation and renewal. There is a sense of urgency--movements are never casual. Alongside the normal tensions of organized life, there is a high level of trust."

HMOs & Public Health Can Collaborate

From "Public Health and Management Care: Changing Roles and Sharing Goals" by Julie Rovner in The Robert Wood Johnson Foundation's newsletter, *Advances*, Issue 3, 1998:

"In Minnesota, the managed care company HeathPartners is working with local public health officials to convince teens not to start smoking.

"In Northern California, state and local public health officials and Kaiser Permanente have jointly created treatment guidelines for diarrheal diseases."

"In San Diego, three major managed care companies joined with hospitals, public health agencies, and local schools of medicine and of public health to work together on a series of projects, including a community diabetes control project, a 'youth-to-youth' hotline, and, by next year, a project to bring low-cost health insurance to some of the estimated 600,000 San Diegans who are currently uninsured."

"These are but three of dozens of examples of new collaborations between managed care organizations and public health departments, joint efforts between sectors of the health system that have traditionally been, if not outright rivals, at least operating nearly in parallel universes. Roz D. Lasker, MD, calls it 'a social movement that hasn't been really recognized before'. Lasker, project director of the Committee on Medicine and Public Health, says that when the committee, with funding from The Robert Wood Johnson Foundation, began to look at examples of collaboration between medicine and public health in 1994, they didn't expect to find much. The idea was to begin fostering such partnerships. But more than 400 examples later, Lasker says, 'we realized that rather than needing to initiate it, what we need to do is help it evolve and help these partnerships be sustained.'"

