

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

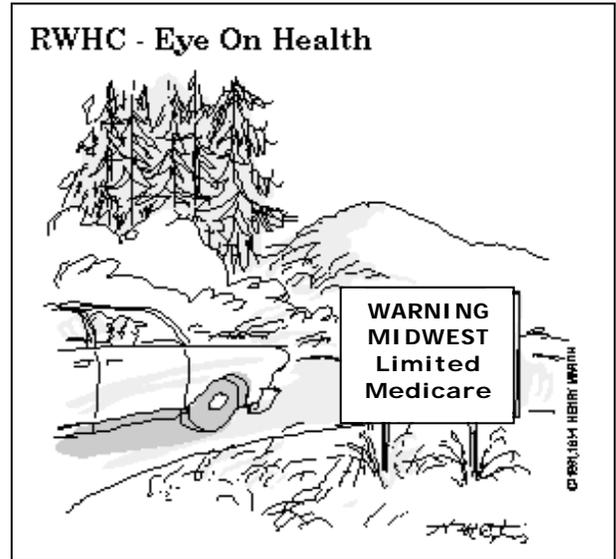
Why Fewer Rural Medicare Benefits?

The following is by Tim Size, RWHC Executive Director, in response to the *Wisconsin State Journal*:

Your article ("Rural Elderly Lack HMO Options," 9/10/99) fairly stated that Wisconsin's "rural elderly lack HMO options" but absolutely failed in its attempt at an explanation. To quote from the Medicare Justice Coalition (initiated this year by the Minnesota Senior Federation, a grassroots organization of 25,000 seniors) "low cost states are severely penalized for delivering quality cost-effective health care while expensive and inefficient health care in some states is amply rewarded by Medicare."

The Coalition correctly points to the problem, "a Minnesota HMO receives about \$405 per beneficiary per month while a Florida HMO receives \$778 per beneficiary per month – almost twice as much! The Result: the Minnesota senior has to pay an additional premium for vital non-Medicare services, an average of \$70 per month in addition to the Part B premium of \$45.50, has no prescription drug coverage, and has co-pays for office visits. The Florida resident, meanwhile, paid no premium for non-Medicare costs, did receive prescription drug coverage, and had no co-pays."

Medicare spending in Wisconsin (rural and urban together) is 25% below the national average, and hospi-



tals lose an average of 4% on every Medicare patient (made up by private payers). Rural providers can't increase their losses by contracting with HMOs for Medicare and "make it up on volume." Even in areas where an HMO and providers can get closer in their negotiations, there are not the dollars available, as in Florida, to add the extra benefits noted above--leaving no reason for a Medicare beneficiary to leave the unrestricted traditional Medicare program for an HMO.

Within the next few weeks, the Coalition expects to bring a lawsuit against the federal government to force Medicare to provide the same Medicare benefits to Seniors wherever they may live. To join the Medicare Justice Coalition as an individual or as an organization or to receive more information call 651-645-0261 or visit:

www.mnseiors.org/medicarejusticejoin.html

Strong Backing for Medicare Equity Claims

The *Dartmouth Atlas of Health Care* is the bible for the increasingly critical consideration of the geographic variation of medical care. It is a product of the Center for the Evaluation of Clinical Sciences, Dartmouth Medical School. John Wennberg, MD, MPH is Principal

RWHC is actively recruiting for an individual to join our senior management team as director of product & member development. Reporting to the executive director, this new position, will be responsible for marketing, new product development, grant writing and member relations. He or she will be an entrepreneur with a proven track record, a deep commitment to rural health and demonstrated skills at collaboration and team building. The appropriate background is flexible with a salary/benefit package being negotiable. Resumes should be sent to RWHC, 880 Independence Lane, P. O. Box 490, Sauk City, WI 53583 c/o Monica Seiler or to mseiler@rwhc.com.

Investigator and Series Editor, and (ironically) published by the American Hospital Association's publishing company.. The Robert Wood Johnson Foundation has decided to extend and expand its support for the *Atlas* which should make it more accessible starting next summer. In the meantime, it can be purchased at <www.dartmouth.edu/~atlas>. The *Atlas* should be on the desk of every health care executive and policy wonk. The quotations below are from the 1998 *Atlas*

"Chapter Seven is a concluding essay that focuses on the debate over what should be done to address unwanted variations in health care delivery. The chapter deals with Medicare fairness and the equity implications of current Medicare formulas for reimbursing managed care health plans. In brief, the policy problem is that Medicare's method of determining payment for capitated care is calculated at the county level (the AAPCC or average adjusted per capita costs). It reflects historical patterns of spending under fee-for-service health care delivery systems in local markets. One result is that differences in spending that cannot be attributed to differences in illness or in prices create unfair subsidies, which are in some cases substantial. For example, on a price and illness adjusted basis, managed care companies enrolling a resident of the Miami hospital referral region received \$8,117 in 1997; managed care companies enrolling residents of the Minneapolis region received only \$4,478 per enrollee. The higher spending for the residents of Miami is funded by taxes collected from residents of all hospital referral regions, including Minneapolis and other regions where Medicare spending is below the national average."

"An unintended consequence of the federal government's AAPCC-based reimbursement policy is that managed health plans being reimbursed at Miami's rate could provide benefits at a reasonable level (such as the level currently provided in Minneapolis) and still have money available to expand the benefit package to include such additional services as prescription drugs, hearing aids and exercise programs. In Chapter Seven, we estimate that managed care companies providing services for residents of Miami could realize a surplus of more than \$3,400 per enrollee for distribution as additional benefits, or retain that amount as profit, simply by achieving the efficiencies of fee-for-service medicine in Minneapolis."

"In a statement contained in The 1998 Budget Resolution, the United States Senate recognized that while 'all Americans pay the same payroll tax of 2.9 percent to the Medicare trust funds and deserve the same choices and services regardless of where they retire,' some regions 'receive 2.5 times more in Medicare reimbursements than others.' In addressing the issue of fairness the Congress inevitably faces the questions, Which rate is right? and How much is enough? In its 'Sense of the Senate Resolution,' the Senate appears to

implicitly accept the national average as the 'right' rate. The statement calls on the Finance Committee to implement policy to reduce the geographic variation in risk plan payment rates by raising 'the lower payment areas closer to the average while taking into account actual differences in input costs.'

"But which rate is right? How much is enough? The national average, whether for coronary bypass grafting, the use of hospitals for medical conditions, the amount of money spent in the last six months of life, or overall Medicare spending has no normative value. It is simply the average of the many different ways of practicing medicine documented in the *Atlas*."

The reality of health care in the United States is that geography is destiny.

"Ideally resource allocation decisions would be guided at the patient level by need, by knowledge of outcomes, and by the tradeoffs patients make between the costs, risks and benefits of care. At the population level, resource allocation decisions would be made based on society's beliefs about cost effectiveness and social justice. The Medicare program's spending would reflect these goals of efficiency, effectiveness and equity."

"We propose a two-part strategy to move the nation closer to this ideal. The first part of the strategy is a patient-level approach to the question of 'Which rate is right?' It is based on outcomes research and the creation of the opportunity for patients to participate actively in the choice among treatments - for example, the choice between lumpectomy and mastectomy for breast cancer, and the choice between surgery and medical management for coronary artery disease. Choices among these options involve significant tradeoffs that only patients are qualified to make. When patients participate in medical decisions (shared decision mak-

The Rural Wisconsin Health Cooperative, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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ing) local rates reflect what informed patients actually want. Areas with such patient-driven rates might well have lower rates of surgery than the current national average. Studies of shared decision making suggest that the demand for invasive treatment by fully informed patients is actually less than the amount now being provided in most markets in the United States.”

“Ideally, the use of health care services by a given population would depend on local levels of illness, and would comprise an efficient mix of preventive, acute and chronic care. Resource allocation decisions would be guided at the patient level by need and knowledge of outcomes, and by the tradeoffs patients made between the costs, risks and benefits of care. At the population level, resource allocation decisions would be made based on society’s beliefs about cost-effectiveness and social justice. Spending by the Medicare program would also reflect the goals of efficiency and equity.”

“Unfortunately, the *Atlas* provides little evidence that these ideals are being achieved - that the quantities of health services and resources consumed by Americans are determined by patient needs and preferences, or by knowledge about the outcomes of care, much less by consensus about society’s needs and priorities. On the contrary the *Atlas* demonstrates that:

- There is wide variation in Medicare spending, and in the supply of acute care hospital resources and physicians among the nation’s hospital referral regions (Chapter Two).
- Hospital capacity has a dominating influence on hospital utilization rates, particularly for medical conditions (Chapter Three).
- There is wide variation in the intensity of hospital care Americans receive during the last six months of their lives, and the variation is closely associated with local supplies of hospital resources (Chapter Four).
- Discretionary surgical procedures have idiosyncratic patterns which result in regional ‘surgical signatures,’ a phenomenon which can be traced to scientific uncertainty about what works and the failure to involve patients in a meaningful way in the surgical decision making process (Chapter Five).
- Variations in illness rates do not explain the patterns of variation in hospital resource supply and Medicare spending (Chapter Six).”

“The reality of health care in the United States is that geography is destiny. The amount of care consumed by Americans depends more on where they live - the local supply of resources and the prevailing practice style - than on their needs or preferences.”

“Practice variations challenge basic assumptions about the nature of the health care economy and theories as to how it should be reformed. While it is beyond the scope of the *Atlas* to consider the question of how policies for addressing unwanted variations in health care delivery might be specifically designed or implemented, the *Atlas* can help frame the debate over what should be done.”

“Surgical variations point to the need for better science at the patient level and the need to bring the patient into the decision process through shared decision making. Through the diligent application of outcomes research, much can be learned about what works in medicine, particularly in those examples of care where a discrete intervention, such as a drug or a surgical procedure, is hypothesized to improve outcomes in specific ways. **By bringing patients into the decision process through shared decision making, health care markets can be improved so that the use of care reflects the preferences of patients, rather than the preferences of providers or payers.”**

Co-op Month Supports Rural Women’s Health

RWHC along with other members of the Wisconsin Federation of Cooperatives is supporting an initiative by the Wisconsin Women’s Health Foundation to hold eight rural women’s health roundtables.

The goal of the roundtables is to inform rural women about cardiovascular disease, breast cancer, osteoporosis, mental health, domestic violence and tobacco use in a casual, personal way and to encourage women, one-on-one to become advocates for their own health. The intent is to begin creating a community of women’s health advocates who are not only learning from the experts, but who are also sharing their knowledge and expertise with each other and in their own local community.

Founded by Wisconsin first lady Sue Ann Thompson last year, your tax deductible contribution to the Foundation will be critical in helping this important, new effort off the ground. It is also a way to make a difference in improving the quality of rural health, an issue Wisconsin cooperatives have long been concerned about.

Please consider celebrating rural women’s health and October Co-op Month by sending an organizational or individual donation, payable to the Wisconsin Women’s Health Foundation to the Wisconsin Federation of Cooperative, 30 W. Mifflin, Suite 401, Madison, WI 53703. If you have questions, please contact Bridget McCann-Horn at WFC, (608-258-4408.

Healthcare: A Lot Is Useless, Much Isn't Done

From the "Snapshots of Substandard Health Care" by Daniel S. Greenberg in *The Washington Post*, 9/1/99:

"The nasty secret of health care economics is that a lot done for patients is useless or dangerous, and costly, and that much that could help them, at relatively low cost, isn't done. Occasionally we get a glimpse into the issue of quality and costs in medicine, but not often."

"Surveying the field of health care studies, researchers at Rand Corp., the California think tank, found a 'surprisingly small amount of systematic knowledge on the quality of health care delivered in the United States,' much of it dating from the 1980s and early 1990s. But after scrutinizing the reviews that have been done, they concluded that 'Whether care is preventive, acute, or chronic, it frequently does not meet professional standards.'"

"The Rand study -- titled *How Good Is the Quality of Health Care in the United States?* -- candidly pointed out that the existing studies provide only 'snapshots' of the American medical landscape. Even so, the review emerged with the 'dominant finding' of serious deficiencies in medical service based on the available studies."

"For example, a study of seven managed-care organizations concluded that 16 percent of hysterectomies in 1989-90 were carried out for 'inappropriate reasons.' Another 25 percent were done for reasons of 'uncertain clinical benefit.' A study in 1990 of 1,335 patients who underwent coronary angiography concluded that 4 percent of the procedures were inappropriate and 20 percent were 'equivocal.' A study in 1988 of 386 cases of coronary artery bypass surgery reported 14 percent as inappropriate and 30 percent equivocal."

"The Rand review found big gaps in the provision of inexpensive, reliable preventive measures. A 1993 study of 8,000 senior citizens reported influenza vaccination for only 52 percent, and merely 28 percent vaccinated for pneumonia. Among 21,600 women over 50, only 58 percent underwent clinical breast examination and 46 percent received mammograms in 1992. Of 128,400 women over 18, 67 percent reported a pap smear in the previous three years."

"The picture that emerges, spotty as it is, indicates that a substantial number of patients are needlessly subjected to serious surgery. Surgeons respond that the chart-reading critics of medical treatment didn't have the benefit of hands-on contact with the patient and can be mistaken in their assessments of surgical necessity. Moreover, a certain amount of surgery of equivocal necessity is deemed desirable for erring on the safe side."

"The Rand study provides a needed glimpse into the rarely examined problem of what the nation is receiving for its huge expenditures on health care. Yes, as we're often told, American medicine is the best in the world. Ailing rich foreigners flock to American medical care. But good as it is, it still could be a lot better. A useful first step would be to supplant snapshots with accurate portraits of how the system actually performs."

RWHC - Eye On Health



"They call us dumb animals? At least we get reminders for our annual medical exam."

Business & Health Leaders on Same Planet?

From the *Employee News Letter* of the Neillsville Memorial Medical Center by Glen Grady, 9/99:

"Recently I, with a number of colleagues, had the good fortune of meeting with several of our state's business organization leaders. They had been invited to talk about what they saw as the biggest issues in health care and what they thought providers should do about it. I believe that almost all of us were at least slightly taken aback by this interchange."

"First of all, they are very aware of what problems are facing the health care community. They know about the Medicare payment reductions caused by the Federal Balanced Budget Act and what a burden it is putting on our industry. They know that due to our large capital needs and the pressures from our labor market that our cost of operations will, indeed, go up. And that in the past, when government programs did not pay their fair share, health care providers just transferred more of the cost to the private payers. They wanted us to know that this cost shift is no longer an option."

"These business people talked about two or three major themes. First of all, they are all competing in a global market place in some way, shape or form. The health care system in most of the other countries they manufacture or do business in are not funded through

employee benefit programs. So they are under a dual type of pressure to either hold the line or reduce their employment cost, or move these jobs south or north of the boarder or overseas.”

“They are competing in the same tight employment market here in the United States that we are all in. They have to have an attractive salary and fringe benefit package in order to hire and retain sufficient numbers of, in particular, skilled employees, to operate their businesses. They can’t afford to reduce the health care benefit they provide their workers or they well might lose them. But they can’t afford to pay more for that benefit either and stay competitive with global competitors. And in fact their workers are demanding more freedom of choice as to what particular doctors and hospitals they go to so much of the savings in health care premiums previously achieved through managed care strategies, are no longer possible.”

“They are also very aware that their health care premium cost is driven more by their employees’ use of high tech specialty care and their demand for more and better health care, than it is by industry pricing. They know full well that one or two heart bypasses, a kidney transplant, the major surgeries and rehabilitation from one victim of a serious accident, and a couple of joint replacements, can easily make up twenty five to fifty percent of a medium sized group’s health care cost in a year.”

“They know it is not the cost of the day to day cold, aches and bruises that are the major drivers of the health care premium. It is the availability and use of new drugs, techniques and technology that keep patients alive, higher functioning and in less pain that are driving the health care premium increases. They blame this on us. They seem to be saying that if we, as an industry, did not provide so many health care solutions, health care costs would be more reasonable.”

“I can understand and agree with part of their premise. There is almost a complete disconnect between the health care patient and the person or entity that ends up paying for the services that a patient receives. There is very little incentive, therefore, for the individual patient to be cost sensitive when accessing health care. This is, of course, complicated by the very technical nature of our industry, making it extremely difficult for most people to be truly knowledgeable about what services they might need. For the most part, they have to rely on the advice of health care professionals to help them decide on what diagnostic and treatment procedures they need.”

“And we, as providers, feel compelled to provide each patient with the type of service that gives them the best possible chance to get well and thrive. We do this, not only because it is our business to care for and about peoples health, but also because if we don’t, the neighbor in the next community will, and our patients will be traveling there for their health care.”

“So while I appreciate the plight of business in trying to hold down their health care premiums, I don’t think that in a free market economy they can rely on the providers of health care to solve the problem of an ever increasing demand for health care services. It seems counter intuitive for any business to try to decrease the publics demand for its product. Free markets abhor a vacuum. If one particular provider voluntarily decided to reduce the number and types of health care solutions available to its patients, their would be no shortage of others willing and able to rush in and fill that void.”

“In retrospect, I guess the business leaders and health care representatives attending this session could not find a middle ground on some issues. But I do think we all came away with a deeper understanding of one another’s problems and perspectives. The dialogue can and will continue. I just hope that acceptable solutions can be found before the cost of health care starts driving too many companies from our shores, or we move completely away from the free market in providing health care for our friends and neighbors, and for one another.”

Employment-Based Health Benefits Update

From an executive summary of the “Employment-Based Health Benefits: Who Is Offered Coverage vs. Who Takes It, 9/99” by the Employee Benefit Research Institute at <www.ebri.org>; EBRI is the only nonprofit, nonpartisan organization committed exclusively to data dissemination, policy research, and education on economic security and employee benefits:

- “This Issue Brief provides data on employment-based health insurance, with a discussion of recent trends and how sponsorship rates, offer rates, coverage rates, and take-up rates vary for different workers. Other sections examine reasons why workers do not participate in employment-based health plans, alternative sources of health insurance, and uninsured workers.”
- “In 1997, 83 percent of the 108.1 million wage and salary workers in the United States were employed by a firm that sponsored a health plan. Of those workers, 75 percent were offered coverage, and 62 percent (or 67.5 million workers) were covered by that plan. Of those workers who worked for an employer that offered them a health plan, 83 percent participated in the plan.”
- “Sponsorship rates have barely changed in the last 11 years. In 1988, 83 percent of wage and salary workers reported that their employer sponsored a health plan. This declined slightly to 82 percent in 1993 but had increased to 83 percent by 1997.”

- “Offer rates significantly changed between 1988 and 1997. In 1988, 82 percent of workers reported that they were eligible for health insurance through their employer. By 1993, the percentage of eligible workers declined to 74 percent, and it has only slightly increased since then to 75 percent in 1997.”
- “In 1997, 40.6 million American workers did not have health insurance through their own job. Forty-five percent of the workers without coverage were employed at a firm where the employer did not provide health insurance to any workers. Thirty-three percent of the workers without coverage were offered coverage but declined it. Twenty-two percent of the workers without coverage were employed in a firm that offered health insurance to some of its workers, but certain workers were not eligible for the health plan.”
- “The 13.7 million workers who were offered coverage but declined it gave a number of reasons for doing so. In the majority of cases (61 percent), the worker was covered by another health plan. Of the remainder, 20 percent reported that health insurance was just too costly.”
- “Overall, 41 percent of the 40.6 million workers who were not participating in an employment-based health plan through their own employer had coverage through a spouse. However, 42 percent of the 40.6 million workers who declined their employers’ health plan or who were not offered health insurance from their employer were uninsured.”

HMO Customer Ratings Fall

From “Satisfaction with Medical Care, Doctors Increases but Customer Service Ratings Fall” at <www.caredata.com> 8/31/99:

“The Caredata Survey has been conducted every year since 1994 and evaluates member satisfaction with 159 managed care health plans in 27 major managed care markets. The 1999 Survey, conducted from May through August of this year, updated results for health plans in approximately half of these markets and was based on responses from 24,802 health plan members. The Caredata Survey is conducted with the assistance of several hundred large employers who use the results to assess their benefits programs and health plan offerings.”

“The new results indicate several important trends in member satisfaction compared to responses from members of many of the same health plans two years ago. Historically, the Caredata Survey has found higher satisfaction levels in HMOs than Point-of-Service (POS) plans, primarily due to customer service issues with POS plans. This year however, POS plan members’

satisfaction rose five points to 54 percent highly satisfied while HMO member satisfaction fell three points to 55 percent highly satisfied. Explaining much of this difference in the HMO/POS satisfaction gap was a nine point drop in customer service satisfaction with HMOs to 48 percent highly satisfied compared to a two percent fall for POS plans to 46 percent highly satisfied. The survey also found that satisfaction with customer service was the most important differentiating factor for consumers in rating their overall experience with their plans -- a key and often cited component of the NCQA’s HEDIS measurement process.”

“Also contributing to the recent equalization between the two types of plans was a fall in pharmacy benefit ratings, down seven points among HMO members to 62 percent highly satisfied but up one point for POS plans to 65 percent highly satisfied. POS plans have an out-of-network option and often offer richer pharmacy benefits but carry higher premiums. In addition, satisfaction with doctors rose for both plan types, although more for POS plans. Sixty-seven percent of members were highly satisfied with primary care physicians in HMOs (up one point) and 66 percent in POS plans (up four points). Seventy percent were highly satisfied with specialists in HMOs (up one point) compared with 72 percent in POS plans (up four points).”

“Tod Cooperman, M.D., president of Caredata.com’s Consumer Research Group (formerly known as Care-Data Reports), commented, ‘The new survey delivers both good news and bad news. The bad news is that ratings of HMOs’ customer service and pharmacy benefits are going down. The good news is that members’ ratings of their medical care are going up, as are ratings of POS plans. I believe that we are seeing the fruit of successful efforts to better position POS plans against PPOs and to further differentiate them from HMOs through investments in separate service centers and enhanced provider networks.’”

Nonprofits & Technology Funding

From the first in a series on technology funding-- “Nonprofits’ Questions About Tech Funding Have Answers” by Shane Thacker, *Philanthropy News Network*, <www.pj.org/technology/techfunding0910.cfm>:

“As nonprofits increasingly seek technological solutions for their needs, there are certain questions that must be answered along the way. One of the most intractable is ‘How do we pay for this?’”

“To begin the series, interviews were conducted with industry professionals to find out what sorts of concerns those with experience in the field might have when it came to technology funding.”

“Meeting the Mission--The area that creates the most universal concern is the need for nonprofits to concentrate on their missions when making technology decisions. This helps the nonprofits’ cause in two ways, the respondents say.”

“First, nonprofits need to be able to decide what is driving them to acquire a particular technology, whether it be as simple as a telephone or as complex as an entire computer network. A nonprofit’s mission is its reason for being. However, just as businesses can forget their primary purpose of making money in a race to have the latest, greatest tech, nonprofits can end up acquiring items that do not help them fulfill their missions at all.”

coop adv

“Steve Downs, director of the Telecommunications and Information Infrastructure Assistance Program (TIIAP) at the U.S. Department of Commerce, says that nonprofits should not forget that the technical requirements should be subordinate to the nonprofit’s reason for being. ‘The role of technology should be to enable nonprofits to do what they do better, to change how they interact with their clients, to reinvent their services,’ Downs says. ‘Technology investments should have clear programmatic goals.’”

“Second, by concentrating on its mission rather than a wish list, a nonprofit can make itself appear to be a more attractive prospect for funding, respondents say. Funders interested in a particular issue will be more likely to give if they can see how the nonprofit is working to resolve that issue.”

“Assessment and Planning--Needs assessment and technology planning go hand-in-hand with an organization’s mission, and respondents agree that those two aspects are absolutely necessary for any organization looking for technology funding. A good technology assessment can help nonprofits refine their requests and make sure they are not simply getting technology for technology’s sake.”

“Operational vs. Project Funding--A common recognition among those interviewed is that funding is often not as readily available for a nonprofit’s operating expenses as it is for specific projects. Jayne Cravens, owner of Coyote Communications and director of the Virtual Volunteering Project, says the perception is often that spending money on operations is the ‘second best’ option. I think this comes from the mentality of supporters and much of the public that all energy and resources must go into ‘direct services’ -- as though putting money into the infrastructure of the organization is somehow taking something away from the audiences served by the organization.”

“While this perception may be changing, nonprofits can help themselves through making sure that needs for operational technology funding are couched in terms of the organization’s mission, or how it can serve its clients better.”

The Ultimate Practical How-To Web Site

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How Do you Know Web Info Is Any Good?

From *Wired for Health and Well-Being: the Emergence of Interactive Health Communication*, prepared by the Science Panel on Interactive Communication and Health's, <<http://scipich.health.org/index.htm>> 4/99:

"The Science Panel on Interactive Communication and Health, an independent body convened by the U.S. Department of Health and Human Services (HHS), released its final report, *Wired for Health and Well-Being: The Emergence of Interactive Health Communication*. The report, a landmark analysis of the emerging field of interactive health communication, identifies specific opportunities for reducing risks and expanding benefits

Federal Government Health Portal

www.healthfinder.gov

associated with these new technologies."

"Emerging communication tools, such as the Internet, can help us spread the prevention message and promote health in ways that previous generations could only dream of," stated U.S. Surgeon General David Satcher. In the foreword to the report, he wrote, "The rapid development of new technologies, coupled with the explosive growth of the Internet, brings opportunities for people to find interactive information, education, and support that is tailored to their needs and preferences."

"The Science Panel was convened to examine the potential impact of health communication technology on the health of the public and to accelerate its appropriate development, use, and evaluation. The Panel coined the term 'interactive health communication' (IHC) to refer to the use of information or communication technology to access or provide health information, guidance, and support. IHC includes health-related Web sites and non-networked software applications."

"To date, there has been little evaluation or quality control of IHC because applications have developed faster than theory and assessment tools," stated Science Panel Chair, David Gustafson, PhD, of the University of Wisconsin-Madison. "With so many consumers relying on health information on the Web, we need to ensure that we do no harm."

"A central area of concern outlined in the report is the lack of public disclosure of information for consumers to judge the credibility of the health information they are viewing and to make informed decisions. With other consumer products, such as processed foods and cars, essential information about the identity of the producer and content of the product are routinely disclosed. The Science Panel proposes that application developers and sponsors routinely post such information on their Web sites or other applications."

"Consumers should be informed shoppers when it comes to the Internet," stated Mary Jo Deering, PhD, Director of Telehealth at the Office of Disease Prevention and Health Promotion, HHS. She pointed out the availability of pre-selected quality online health information resources for consumers at <www.healthfinder.gov>, the federal government's health portal."

