

Review & Commentary on Health Policy Issues for a Rural Perspective – June 1<sup>st</sup>, 2003

## Ignore Small Business Struggle At Your Peril

From “Health Insurance System Broken In Wisconsin,” a position paper from the Wisconsin Independent Businesses (WIB), 5/13/03:

“The Wisconsin health insurance system doesn’t work. It doesn’t work for employers, workers and farmers. It apparently does work very well for the insurance industry, because the industry works so hard to prevent any consumer-friendly changes to the current system. State government, given many opportunities to help reform health insurance, has constantly ‘studied’ the problem but has failed to use united aggressive leadership that could actually lead to change and reform.”

“It is no surprise that growing numbers of Wisconsin citizens, including business and farm owners, believe that only a dramatic overhaul of the current system will bring them quality health care coverage and stable costs. Wisconsin Assembly Bill 229 certainly proposes a dramatic overhaul in the system.”

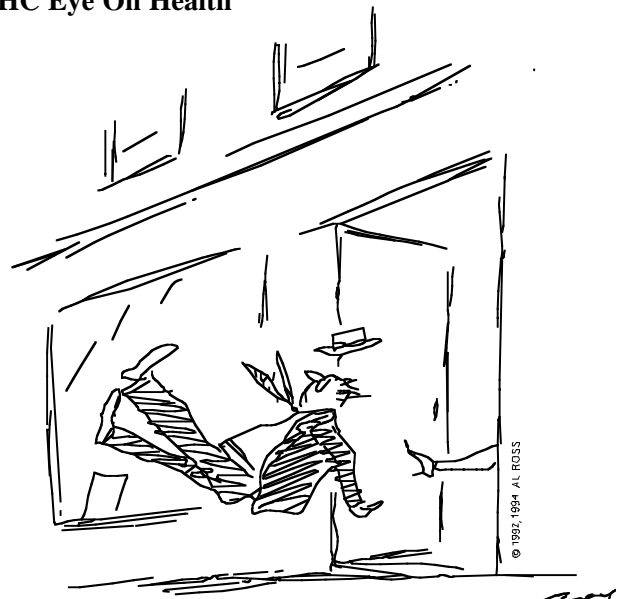
“In 1989 a somewhat similar bill with a payroll tax as the funding mechanism was introduced in the Assembly. Hundreds of WIB members showed up to strongly protest the payroll tax at a series of hearings around the state. Today we would be unable to generate that passionate opposition.”

“WIB recognized in 1989 that universal coverage funded through a payroll tax might eventually have appeal to business owners trapped by out-of-control insurance rate increases. A government-based program funded with a payroll tax is the type of system

business owners normally reject out of hand. The failure of the insurance industry and state government to resolve the problem has led some business owners to be remarkably open to the concept addressed in AB 229. **Growing numbers of business owners believe that desperate times call desperate measures. For health insurance consumers in Wisconsin these are assuredly desperate times!**”

“There are, however, options available. The Private Employer Health Care Coverage Program was approved by the legislature in 1999. If not for the ill-considered veto of rate band reform and startup funding by Governor McCallum in 2001 that program would be operating today. The Private Employer Board, on the recommendation of the Institute for Health Policy Solutions, has asked the Doyle

### RWHC Eye On Health



The small business health insurance crisis gets better once we say "enough already" to the Perfect World Society on one side and the Robber Barons on the other.

Administration and legislature for small group market rating reforms. It can be done by administrative rule or legislation but it must be done immediately.”

“Additionally, Assembly Bills 312 and 313 would allow self-employed persons and farmers to purchase health insurance plans available to state employees through the Group Insurance Board and the Private Employer Program. WIB strongly supports these additional health insurance coverage options.”

“In 1989 legislators recognized that there was a growing health insurance crisis in Wisconsin. 14 years later, despite legislative passage of the Private Employer Program, state government continues to virtually ignore the crisis. The insurance industry has no credibility with business and farm owners in Wisconsin. **Bluntly, people don’t believe the industry’s constant claims that disaster lurks with reform. Our health insurance consumers are demanding reform. The health insurance industry has refused to lead that reform. The legislature must again take the lead.**”

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## Minnesotan Frames Health Reform Issues

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From “Reforming Minnesota’s Health Care System” by David Durenberger in *Minneapolis Star Tribune*, 4/18/03:

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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“The April 13 *Star Tribune* editorial ‘A Balanced Approach to Health Care Costs’ suggests deeper cuts in payments to health plans and providers as a way to address our budget shortfall. This proposition is short sighted and merely shifts the burden from the state to our providers.”

“We are not going to solve our cost problems simply by changing how we pay for things or by reducing the number of people who receive services. Any budget control effort will be sabotaged by the continued, uncontrolled health care cost increases that far exceed the state’s projected revenue growth.”

“To maintain Minnesota’s high-quality health care as well as to arrest costs over the long term, we must confront the root cause of health care cost increases—the systemic dysfunction of our health system.”

“Many people have proposed innovative ideas for health care reform, but there is no consensus about the best direction to take. Some initiatives offer new ways to pay for health care, while others address the quality and quantity of the health care product. It is critical that any reform effort reflects the multifaceted pressure that we confront—the costs, volume, and delivery of goods and services. Focusing on any one of these factors without acknowledging the impact on the others cannot lead to consensus.”

“At the heart of any reform effort must be the professional-patient relationship. The National Institute of Health Policy (NIHP) has developed a framework for health care reform that captures the best ideas and offers an achievable vision for change while significantly curbing the rise in costs.

- The greater use of evidence-based medicine. We know that if all doctors in the United States practiced as efficiently as the top 10 percent, we would save enough money to add a drug benefit to Medicare and have funds to spare. We need to have practice guidelines that are available to and understandable by patients and families. We need a state and national political consensus to pay only for high-quality services.
- The application of evidence-based operations. Our health systems’ operations are inefficient. The health care industry’s rate of productivity in-

crease hovers around 0.8-0.9% per year compared with 3-4% in other industries. What we have is a cottage industry in which each organization operates in an idiosyncratic manner based on its history, leadership, and providers. What we need is a new paradigm that combines the art and science of medicine with the best operating practices of our nation's most efficient industries.

- New methods to lower financing and transaction costs. Health care transaction costs—the cost of paying bills—account for 4% of our GDP. The exchange of information and funds between payers and providers is wrought with burdensome and complex systems. In some cases the process is partially automated, but, in many cases, paper is still needed. We need to find ways to reduce the cost and volume of paper exchange.
- A more active role for the consumer. We know that many consumers over use the system, are uninformed about the costs of health care, and make poor lifestyle choices that lead to costly illnesses. But we also know that consumers will make good choices when they are motivated to do so. We need create incentives that will encourage us to be more involved in our health care, to live healthier lives, and to use the health care system more judiciously.”

“Our health care system is extremely complex and political, and change is difficult. When change comes (and it will), we all must play a role. When change comes, it will be because all of us have done our part.”

*David Durenberger (U.S. Senate, '78-'95) is Chairman of the National Institute of Health Policy at the University of St. Thomas. He also will Chair a Governor's Task Force on Health Care in Minnesota.*

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## President Proposes Medicare Experiment

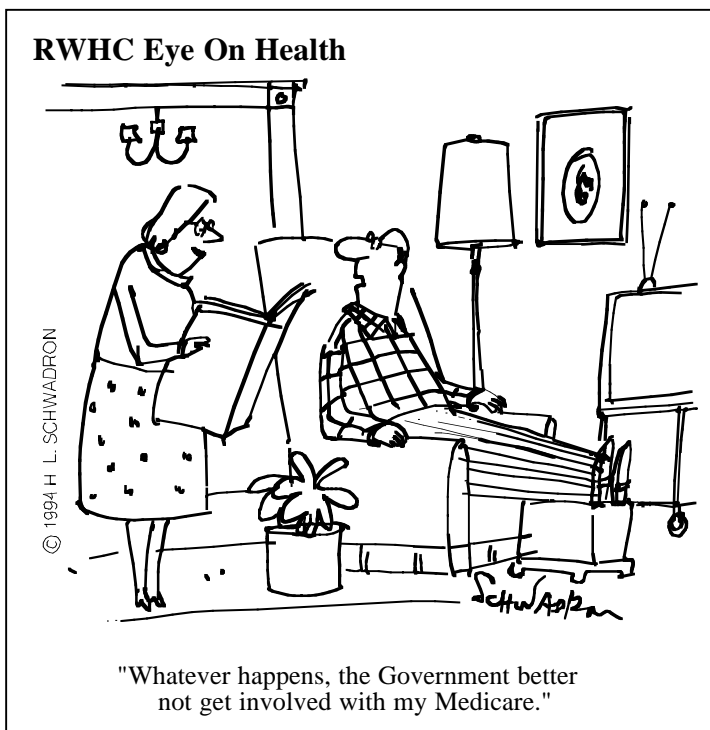
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From “On Medicare, Bush Left Details to Congress, President Offered Blueprint for Change Without Specifics on Drug Subsidies, Feasibility” by Amy Goldstein in the *Washington Post*, 4/20/03:

“In essence, Bush's Medicare framework is a compromise between the administration's conservative ideology and its pragmatism. Facing resistance within his party—as congressional Republicans accused the White House of bungling the plan's development and of failing to help enough elderly people afford prescription drugs—Bush's framework is less far-reaching than some in the administration would have liked. Still, the proposal's most innovative aspects would rely on parts of the health care marketplace that have little experience with Medicare patients.”

“According to lawmakers and health policy analysts across the ideological spectrum, the details that Bush omitted leave basic questions about whether the White House's framework makes sense. Among the uncertainties: Would all 40 million elderly people on Medicare get enough help in paying for medicine? Are private health plans willing to take part? Can the changes Bush wants fit within his price tag of \$400 billion over the next decade? And—crucially—would the approach save money at a time when Medicare faces severe financial strains?”

“In essence, Bush's ‘Framework to Modernize and Improve Medicare’ embraces the long-standing Republican goal of tilting the 38-year-old health insurance program toward a private marketplace in which insurers compete to provide medical care to older Americans.”



“The framework ‘is part of the same mantra of, ‘We’ve got to get people out of the traditional Medicare program into some form of private coverage,’ ’ said Stuart Altman, health policy researcher at Brandeis University.”

“But that goal has been tempered by two other considerations that the administration viewed as politically essential: The White House wants to be able to promise that Medicare patients could stay in the original ‘fee-for-service’ part of the program—and that they would not be corralled into HMOs, which are widely unpopular.”

“In its final form, Bush’s framework weaves together all three goals. The new version of Medicare that he envisions would rely on two kinds of private health plans that are less restrictive than health-maintenance organizations. These would be ‘preferred provider organizations’ (PPOs), which encourage patients to use doctors and hospitals within a specified network, and a newer form of insurance known as ‘private fee-for-service’ plans. Patients in such plans pay a fee for extra medical services and closer coordination of their care, but they can visit any health care provider willing to take part.”

“The plan avoids any appearance of pushing anyone out of original Medicare. Instead, it would try to coax people into the new version by offering them more generous coverage. Only that version would for the first time place a ceiling on how much elderly patients must pay in hospital bills. The main inducement would be better coverage for prescription drugs.”

**Employee Retention in Healthcare: June 17<sup>th</sup>, 9 to 3 at the Cleary Alumni Center, UW La Crosse**—We can manage employee retention in the healthcare industry. Spend a day with other human resource managers, retention officers, recruiters, administrators, and vice-presidents in our area to share ideas and develop initiatives to retain employees. The program speaker/facilitator is Elaine Estervig Beaubien, author, keynote speaker, and award-winning educator, who has worked with many Wisconsin healthcare entities such as University Hospitals and Clinics, Black River Memorial Hospital, St. Joseph’s Hospital-Marshfield and the Wisconsin Hospital Association Go to [www.rwhc.com](http://www.rwhc.com) and click on NEW for more information and registration form. Sponsored by RWHC and many others.

ment would be better coverage for prescription drugs.”

“The White House has not made public its thinking about how much money patients in the traditional program would have to spend before such ‘catastrophic’ coverage started. But at congressional briefings, the White House indicated that it might seek to cover people who spend more than \$4,000 or \$6,000 a year on medicine. In either case, that would mean most Medicare patients who stay in the original program would not get any help.”

“The drug subsidies for people who stay in original Medicare are a critical feature of how Bush’s plan would work. They would determine how much money was left over for extra services for people in the new health plans—and how many people would want to join them. The framework does not include any predictions, but two sources said the administration has concluded that nearly half of all Medicare patients would join new health plans.”

“According to lawmakers, researchers and insurers, such private health plans—the crux of Bush’s framework—will take part in Medicare only if they can get enough patients and enough money to make it worthwhile. ‘That always has been the question—whether [private insurers] would show up,’ said House Energy and Commerce Committee Chairman W.J. ‘Billy’ Tauzin (R-La.)”

**The Breast Cancer Recovery Foundation’s Infinite Boundaries Retreats** encourage breast cancer survivors to overcome some of the limitations they may have set for themselves by discussing their emotional response to the disease and by exploring new physical challenges. Designed by breast cancer survivors for breast cancer survivors, each retreat features a volunteer team of breast cancer survivors who assist with group discussions and physical outings.

**Openings remain for July 31st to August 3rd on Madeline Island, Lake Superior.**

Fees are adjusted as needed by the participant. Go to [www.bcrf.org/](http://www.bcrf.org/) for information or call 608.821.1140

“Medicare has relatively little experience with the two kinds of health plans on which Bush wants to build the program’s new part, although federal law has allowed them since 1997. Until last year, the main preferred-provider organization in Medicare was available only in Houston, but last summer the administration started an experiment to attract additional plans by offering them a better financial deal. In the past few months, 31 such plans have agreed to take part, federal figures show. So far, they have enrolled a fraction of Medicare’s 40 million patients -- 58,000 people, most of them in New Jersey, where a large HMO had just dropped all its elderly patients.”

“Similarly, three private fee-for-service plans participate in Medicare. The first one, offered by Sterling Life Insurance, began three years ago and enrolls 21,000 patients in portions of 25 states. The plan does not now offer drug coverage, as Bush wants. Another similar plan offered by Humana Inc., which does include a drug benefit, began last year in a single county outside Chicago, and expanded two months ago into several parts of the upper Midwest. A third plan, by UniCare, is so new that it does not yet have any patients.”

“Despite Medicare’s scanty experience with such plans, administration officials consulted with insurers and are confident they would take part. Others, on Capitol Hill and beyond, are less certain and wonder if they would save Medicare money, even if they do.”

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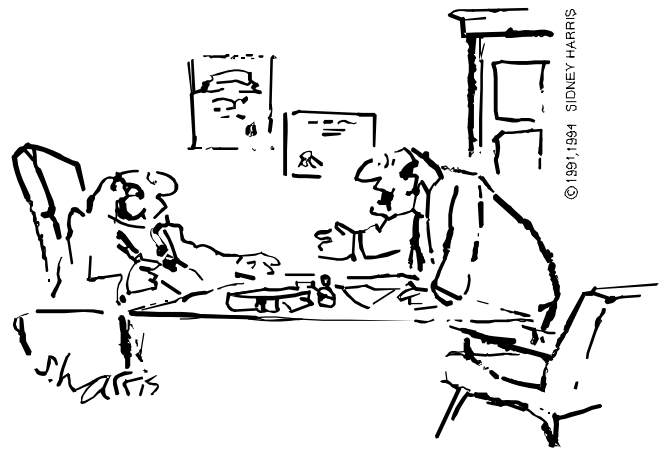
## Rural Best Practices Not Always Small Urban

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From a classic, *The Environmental Context of Patient Safety and Medical Errors* by Douglas Wholey, Ira Moscovice, Terry Hietpas & Jeremy Holtzman, Rural Health Research Center Working Paper #47, University of Minnesota, 3/03. Contact Jane Raasch <raasc001@umn.edu> for a copy of the paper:

“Interest in the issue of patient safety and medical errors has accelerated over the last decade, most recently culminating in widespread media attention and policy consideration by state and national levels of government, accrediting bodies, health care organizations, and employer groups. The purpose of this

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“Don't like accountability and evidence based medicine--get over it.”

paper is to explore the environmental context of patient safety and medical errors in rural settings. We review the patient safety/medical error literature, point out unique features of rural health care organizations and their environment that relate to the patient safety issue and medical errors, summarize relevant organizational theory, and conclude by discussing strategies for medical error reduction and prevention in rural health care settings.”

“There is little evidence to evaluate how the level of patient safety and quality of care differs between rural and urban settings. We model the rural hospital as complex systems that adapt to face a distinct environmental context. Organizational research shows that organizations, as complex systems, adapt to fit their context. Complexity is a function of organizational size, technological complexity, and environmental complexity. These differences in organizational environments result in variation in processes, information flows, the culture of safety, and organizational learning to improve safety between rural and urban hospitals.”

“We discuss rural-urban differences in hospital processes, information flows, the culture of safety, and organizational learning and develop the following hypotheses about these differences:

- Rural hospitals will have a greater proportion of adverse events associated with the elderly than urban hospitals.

- Rural hospitals will have a lower proportion of adverse events associated with over-learning (*a high volume related error*) than urban hospitals but a greater proportion of adverse events associated with medical training that emphasizes work in a more specialized environment.
- Rural hospitals will have a lower proportion of adverse events associated with information flows between the patient and the hospital than urban hospitals due to enhanced social embeddedness.
- Rural hospitals will have a greater proportion of adverse events associated with informal communication processes within the hospital than urban hospitals.
- Rural hospitals will have a greater proportion of adverse events associated with triage-and-transfer decisions and a greater proportion of adverse events associated with transporting patients than urban hospitals.
- Rural hospitals will find it easier than urban hospitals to build a culture of safety based on a feeling of being in a community, but will find it more difficult to build tools such as anonymous reporting systems.”

“We conclude by discussing how learning processes can be developed in rural hospitals to help health services researchers to work effectively as partners with rural hospitals. Two questions need to be examined to understand how organizational learning to improve patient safety can be facilitated in rural hospitals:

- When and how should rural hospitals explore new technologies (i.e. global technologies) and processes by adopting them?
- When and how should rural hospitals exploit their existing technology and processes by refining them?”

“These are fundamentally different strategies to reduce errors. Because organizations have budget and personnel constraints, they often cannot pursue both simultaneously. But doing either one exclusively can lead to sub-optimal performance. Two strategies are

identified for helping rural hospitals to manage the learning process about errors:

- Decrease system ambiguity, formalize technologies to decrease uncertainty, and identify countable events that can be monitored.
- Develop common measures across rural hospitals that allow them to determine if they are falling into a competency trap.”

“We argue that rural hospitals differ in systematic ways from larger urban hospitals and measures specifically designed for rural hospitals (e.g. timeliness and safety of the patient transfer process) are likely to be required if they are to be useful in helping rural hospitals to balance exploitation and exploration optimally.”

“We currently know little about patient safety and medical errors in the rural context. The time to learn about patient safety, medical errors and successful interventions in rural hospitals and environments is now. The reduced scale and complexity of rural institutions provide an excellent laboratory for examining patient safety and medical errors issues. An important next step is financial and technical support for the systematic collection of data from rural hospitals and other entities that will lead to relevant patient safety practices for rural America.”

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## Home Grown & Deadlier Than Cigarettes

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From the Wisconsin Public Health & Health Policy Institute May 8<sup>th</sup> Forum: “Obesity will soon overtake smoking as the leading preventable cause of death. Obesity already has greater morbidity than either smoking, problem drinking or poverty.” **Not all obesity is preventable but much is.** From “An Ounce of Prevention: What Can Policymakers Do About the Obesity Epidemic?” which can be found at:

[www.medsch.wisc.edu/pophealth/StateForums/](http://www.medsch.wisc.edu/pophealth/StateForums/)

“Overweight and obesity is a major problem. The percentage of the population that is overweight or obese continues to increase. Overweight and obesity

are key factors in many diseases. Yet, to date the response from public and private policymakers has been relatively small and uncoordinated. The good news is that should policymakers want to take action, a number of policy options are available.”

“The federal Centers for Disease Control and Prevention reports that in 2001:

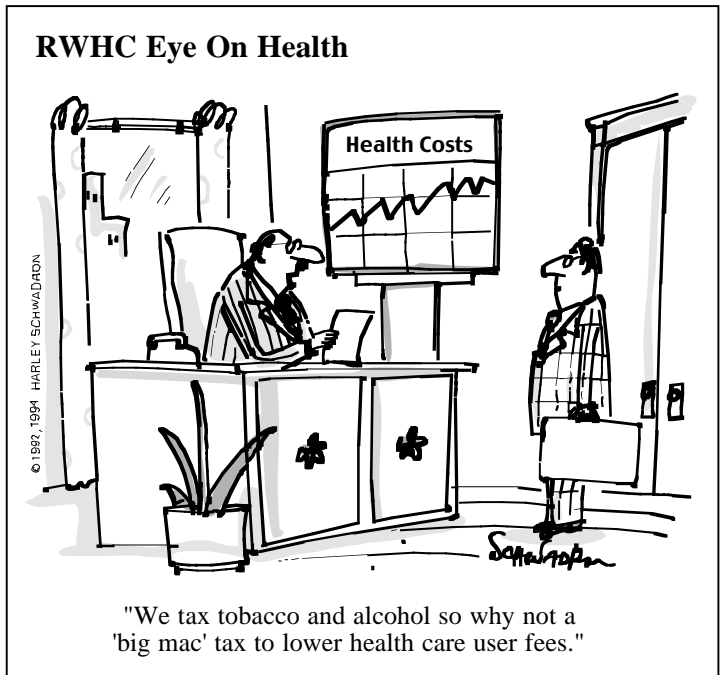
- 37% of Wisconsin adults were overweight.
- An *additional* 22% were obese.
- The percentage of obese adults in Wisconsin *doubled* between 1990 and 2001.
- 15% of children aged 6 to 19 were overweight.”

“Wisconsin’s numbers are similar to the national prevalence of overweight and obesity. Because the number and percentage of people who are overweight or obese nationwide is so large, experts on these conditions now say there is an obesity epidemic. Being overweight or obese increases a person’s risk of developing many medical conditions including hypertension, high cholesterol, diabetes, heart disease, heart failure, and stroke.”

“The federal Centers for Medicare and Medicaid Services reports that healthcare costs totaled \$1.4 trillion in 2001. If 5.5% of this cost is attributable to obesity, the national cost of obesity is \$77 billion per year. Wisconsin’s per capita share is \$1.4 billion.”

“Both governmental and private sector actors have begun efforts to combat the obesity epidemic. However, many of these efforts lack urgency because obesity is a low priority. In addition, these efforts are not linked together or part of a systematic public/private partnership to tackle the problem of excess weight.”

“The challenge facing policymakers, public and private, is not only to increase efforts to combat the obesity epidemic, but to do so in a way that sends a consistent message to kids and adults in school, the workplace and the community. Some pieces of this puzzle are already in place. Others will need to be built from the ground up.”



“Possible specific areas of action include:

**Restrict or eliminate junk foods in schools.** States have wide latitude to control the sale of food in schools.

**Improve access to healthy foods in schools.** Only 51% of Wisconsin middle and high schools offer healthy foods for sale.

**Improve health education curricula to provide information on nutrition.** Wisconsin does not require classroom instruction in nutrition. Only 71% of middle and 76% of high schools offer such instruction.

**Link school food policies with nutrition curricula.** Only 35% of Wisconsin middle schools and 44% of high schools meet the dual standard of teaching about and making available healthy foods.

**Increase physical education instruction in schools.** Wisconsin’s physical education requirements fall short of those recommended by the National Association of State Boards of Education. The NASBE recommends daily physical activity – 150 minutes per week for elementary grades and 225 minutes per week for middle and high school grades.

**Eliminate sales tax exemptions on unhealthy foods and dedicate the money to health programs.** Sev-

enteen states and the District of Columbia have enacted laws taxing soft drinks and/or snack foods.

**Promote policies that encourage walking and bicycling in everyday life.** Examples include community designs that provide sidewalks and bike lanes, transportation funding for biking and walking in highway projects, safe routes for walking to school.

**Maximize state receipt of federal money.** Numerous federal programs provide money to states for efforts to increase physical activity.

**Improve workplace wellness programs.** Public and private sector employers can reduce healthcare costs by helping individuals become aware of the need for physical activity and by establishing financial and other incentives to make individuals responsible for their own health.”

“Without concerted, coordinated, and immediate action on the part of state and local governments, educators, insurers and medical providers, and private companies, the number of people who are overweight and obese will continue to grow. It is an epidemic

with enormous costs that has been too long neglected. These costs are avoidable, but only if we act.”

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## Warm Drippy Nose Replaces Cold Needle

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From “Man’s Best Friend to Be Trained to Sniff Out Cancer,” Reuters, 4/28/03:

“Man’s best friend is to be trained to sniff out the leading cause of cancer in British men. Researchers from Cambridge University, England, and the city’s renowned Adenbrooke’s Hospital are to apply for funding for a trial to use dogs to detect signs of prostate cancer, which affects over 20,000 British men a year, in urine.”

“ ‘We will train the dogs to distinguish the odor of urine from men with malignant prostate,’ Dr. Barbara Sommerville, who is leading the research, told the *Sunday Times* newspaper. The 12-month trial will involve Alsatians and Labradors, with the dogs’ success rate recorded at the end of the training.”

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