

Review & Commentary on Health Policy Issues from a Rural Perspective - January 1st, 2000

Midwest Based Medicare Rebellion Spreads

From Press Release by Wisconsin Governor Tommy Thompson, 12/16/99:

Gov. Tommy G. Thompson said today the administration is preparing to sue the federal government because its Medicare reimbursement program treats Wisconsin patients in an inequitable and unfair manner.

Gov. Thompson said Wisconsin taxpayers are not receiving their fair share of federal Medicare dollars, which is resulting in Wisconsin patients (namely senior citizens) paying more to receive lesser health benefits than patients in other states.

Gov. Thompson said Wisconsin and other smaller states often come out on the short end of federal formulas for programs like Medicare because bigger states have more votes in Congress, thus they are able to tailor these programs to their maximum benefit.

The governor said the political realities show the Congress won't create a fair system on its own, so the state is forced to seek equity through legal means.

"This is about Wisconsin taxpayers getting equitable coverage under Medicare and a fair return on their tax dollar," Gov. Thompson said. "Wisconsin is going to become more aggressive in make sure our taxpayers are treated fairly by Washington."

Currently, Medicare HMOs in states like New York and Florida receive higher federal payments, which allows them to provide a wider array of benefits at little or no cost to the recipient. By comparison, an HMO in Richmond County, New York, receives a reimbursement rate of \$798.35 per month and an HMO in Dade County, Florida, receives a rate of \$778.45, but an

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HMO Plan	PrimeCare Health	Physicians Healthcare
Service Area	Milwaukee Area	South Florida
Monthly Premium	\$30 per month	\$0
Physician visit	\$20 per visit	\$0
Prescription Drugs	No coverage	Full coverage of all plan-approved drugs.
Dental Exams	No coverage	Full coverage of all preventive exams.
Physical Exams	\$20 per exam Limit 1 per year	\$0 No limit per year

HMO in Milwaukee County gets \$452.31 and an HMO in Dane County gets \$386.05.

As a result of these disparities, Wisconsin seniors pay more for lesser benefits than patients in big states like New York and Florida.

For example, a Medicare patient with PrimeCare Health Plan in the Milwaukee area pays \$30 a month in premium, \$20 per doctor visit, \$20 per physical exam with a limit of one per year and gets no prescription drug coverage or no dental exam coverage.

If that same Medicare patient were with Physicians Healthcare Plans in South Florida, he or she would pay no monthly premium, no money per doctor visit, no money for physical exams with no limits on the number per year and receive full coverage for prescription drugs and dental care.

Gov. Thompson said it is unconscionable that the federal government perpetuates such great disparities in health coverage between states by providing such great inequities in Medicare payments.

Gov. Thompson said. "This makes absolutely no sense. Wisconsin taxpayers are paying their fair share for Medicare in this country and they should receive their fair share of services as a result." Gov. Thompson said the administration is currently working on a legal strategy for seeking changes to the Medicare payment system in federal court. More details will be released once finalized.

Wisconsin currently ranks 50th among the states in the amount of federal money it receives. The Governor said the federal government doesn't need to spend more but it does need to more fairly spend the money it collects from each state.

Medicare Justice Coalition--How We Got Here?

From "Geographic Discrimination?" by David Brauer in *salon.com* <www.salon.com>, an e-magazine. This article focuses on Minnesota but the lawsuit is supported by Wisconsin organizations and individuals as well as others in similarly disadvantaged regions:

"Minnesota residents are not suffering from bad health care; treatment costs are among the lowest in the country. But they are victims, a new suit claims, to geographic discrimination by the federal government. Millions of Americans are affected by Medicare's varying subsidies to local HMOs, but Minnesota is the first state to do something about it."

"Residents of places as diverse as Honolulu, Albuquerque, Salt Lake City and Rochester, N.Y., as well as most rural towns, are paying hundreds more for far less coverage than those throughout the urbanized Sun Belt and in many big Eastern cities, according to a study by the Dartmouth Atlas of Health Care."

"'This is a nationwide rural health-care issue,' says Peter Wyckoff, executive director of the Minnesota Senior Federation, Metropolitan (Minneapolis-St. Paul) region, a consumer rights group."

"A federal lawsuit filed here last month alleges that reimbursements in the 39-million-person program are so geographically irrational that they are unconstitutional. The suit claims that individuals are denied the Fifth Amendment right to equal protection under the law."

"'It's as if you could double your Social Security check by moving from Minnesota to Miami. Nobody would think that was fair,' says Megan McAndrew Cooper, editor of the Dartmouth Atlas of Health Care, which tracks local coverage differences. 'Everyone pays into Medicare at the same rate, but some people are getting twice as much out of it.'"

"Seventy-two-year-old Mary Sarno would probably agree. Sarno, who lives in Florida, wants to be near her

daughter but in court filings says she simply can't afford to move to Minnesota, where her daughter lives. Sarno and her husband claim that they can't afford to pay the \$800-a-month increase in drug costs. The suit claims unfair Medicare subsidies not only violate Sarno's equal-protection rights, but her constitutional 'right to travel.' (This argument was used recently to overturn state welfare laws that gave smaller payments to newcomers.) Courts have decreed that the government cannot create barriers to people moving freely between states."

Rural Health Policy Institute 2000



National Rural Health Association
February 7-9, 2000, Washington, D.C.

202-232-6200 to register or
www.NRHA Rural.org

Talk with Administrator Nancy-Ann Min DeParle of the Health Care Financing Administration.

Much of the BBA Relief (Medicare payment changes) just passed by Congress is the result of a united rural front through and with the NRHA. But much work is still to be done. Join RWHC and other NRHA members at the policy institute to be part of our ongoing fight for reforms.

"Although Sarno is effectively a stand-in for millions of Americans allegedly hurt by Medicare rules, she won't talk about her situation to maintain her privacy, according to her attorney."

"And the defendants aren't saying much either. Although formally, the defendant in this case is Health and Human Services (HHS) Secretary Donna Shalala, supporters of the suit say their true gripe is with Congress. Dr. Robert Berenson of HHS issued a short statement after the suit was filed, shifting blame to legislators. 'The law typically sets the methodology Medicare uses,' Berenson wrote. 'We consistently work within those laws and with Congress to ensure that Medicare beneficiaries can receive quality care in all regions of the country.'"

"The reimbursement saga seems to be a textbook case

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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of unintended consequences becoming politically ossified. In 1965, Congress created Medicare to ensure coverage for all Americans over 65 and the disabled. The program did this on a 'fee-for-service' basis -- paying more when seniors use more services."

"But in the '80s came managed care, which promised rigorous cost-containment so patients could get 'more efficient' coverage for less. Subsequently, seniors flocked to these managed care programs, enticed by small co-payments and prescription drug coverage not covered by traditional Medicare."

"Congress paid each HMO based on the average cost to treat patients in each U.S. county. Areas like Minnesota and upstate New York, which adopted aggressive managed care early and bled costs out of their systems, got smaller reimbursement checks. Paradoxically, other places that didn't clamp down on total medical spending were rewarded. These included areas with hospital building booms, such as south Florida and parts of Arizona, or areas that couldn't politically close down hospitals with excess beds, such as New York City."

"'It wasn't obvious what was going on,' says Cooper of the Dartmouth Atlas of Health Care. 'But a hospital buys an MRI and doctors use it; an area's total costs go up. You build a hospital, and doctors tend to fill those beds.'"

"Although there has been some legislative reform, drafted to fix the price discrepancies, critics say it doesn't go far enough. That's why they say the suit was filed -- to achieve in court what they couldn't through

normal legislative channels. 'Politics simply hasn't worked,' says Wyckoff."

"Supporters of the suit claim that Minnesotans and similar locales have little to lose; a successful suit would simply help them. Local HMOs would get more business; seniors such as Grigsby and Van Guilder would get more choice (and presumably better coverage); and local hospitals would get more traffic if seniors have more Medicare dollars to spend."

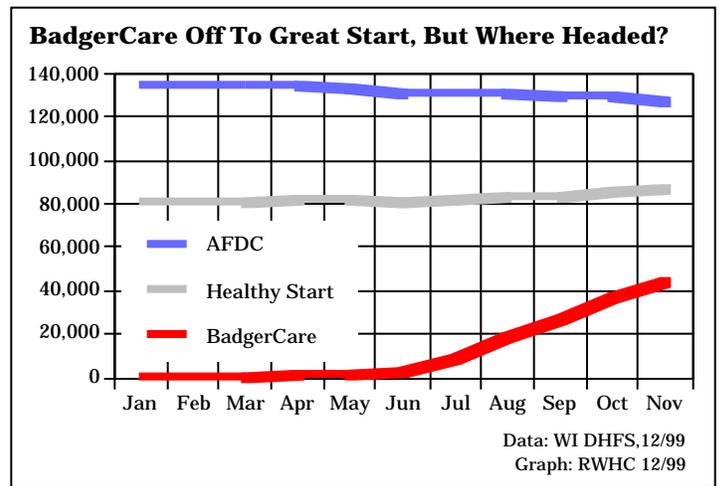
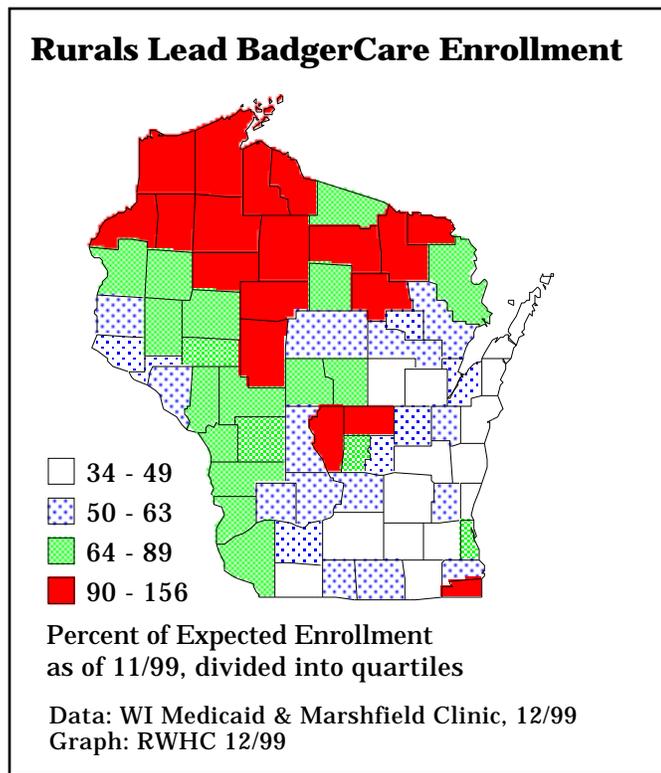
"But it's not clear what kind of ramifications a successful suit would have for parts of the country now benefiting from higher reimbursements."

"At least, this lawsuit raises awareness of the discrepancies in senior health care. If the pressure mounts, then maybe, advocates say, Congress will draft a more equal system -- so you couldn't know what city you were in just by looking at your health coverage plan."

BadgerCare--WI Legislature's Work Not Done

BadgerCare is Wisconsin's version of the federally supported Children's Health Insurance Program. Unlike most states, Wisconsin provides health insurance for uninsured working families - for both children and their parents. In five months, this program has taken off like a rocket, in large measure due to meeting the long time need of uninsured rural working families.

But where are we headed? Major rumblings are already being heard from managed care companies who are threatening to pull back from BadgerCare due to major, early losses. Initial reimbursement rates were set by the State based on the younger and healthier population previously insured under State Aid to Families With Dependent Children (AFDC). Additionally, no adjustment was made for the pent up demand for initial services by entering families not previously insured. From <www.dhfs.state.wi.us/badgercare/>:



“By insuring both children and their parents, Badger-Care makes it easier for parents to create a happy and healthy family life.

- ✓ To be eligible you must have children under age 19 living with you.
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If you think you might be eligible, call today and get your eligibility process started. Call: 1-800-362-3002

Tobacco Money--Even New York Gets It Right

From “New York Doubling Cigarette Tax to Pay for Health Care for Poor” by Raymond Hernandez in *The New York Times*, 12/17/99:

“Gov. George E. Pataki and legislative leaders from both major parties agreed today to raise the state's cigarette tax by 55 cents a pack in an effort to provide health care coverage for as many as one million uninsured New Yorkers.”

“Mr. Pataki and leaders of the Legislature also decided to renew a program that pays hospitals about \$1.3 billion a year to train new doctors and treat poor people who show up in their emergency rooms with no way of paying their bills. The program had been set to expire at the end of the year, threatening the state's health care system with financial uncertainty.”

“The plan to expand coverage for the uninsured is expected to cost the state about \$750 million over the next three and a half years. It would be financed with

revenue from the added cigarette tax, as well as a share of the \$450 million a year that the state is to receive from the settlement of the national lawsuit against tobacco companies. The plan would also be paid for with about \$300 million in new federal health care funds.”

Loose Guns--The Tobacco Issue For 2000?

From, “U.S. Laying Groundwork in Bid for Safeguards on Weapons,” by David Stout in *The New York Times Company*, 12/8/99:

“In a move to force the firearms industry to adopt safer ways of making and selling weapons, the federal government said on Tuesday that housing authorities around the country were planning to file a class-action lawsuit against gun makers.”

“The administration is throwing its weight behind suits filed by more than two dozen cities against gun companies in the hope that a far-reaching settlement might be achieved, said Housing Secretary Andrew M. Cuomo and Bruce Reed, President Clinton's domestic-policy adviser.”

“The suit would accuse the arms industry of marketing and selling weapons irresponsibly so that they often fall into the hands of criminals and of failing to make firearms as safe as possible. But Cuomo said the federal goal was a settlement, not a drawn-out lawsuit. ‘If all parties act in good faith, we'll stay at the negotiating table,’ he said. ‘If not, we are prepared to litigate. We feel we're in a strong position.’”

“Cuomo said that if no settlement was reached, the suit would be filed in Federal District Court. Technically, the suit would be lodged by the nation's 3,200 public-housing authorities. They have an enormous stake in the issue, Cuomo said, because of violence in the projects, where the government spends \$1 billion a year on security, but where many children are so afraid of stray bullets that they sleep in bathtubs.”

“Reed said the federal government, like the cities that have sued the firearms industry, sought curbs on advertising; compulsory child-safety locks on handguns and stricter rules on sales and distribution. ‘One percent of the gun dealers sell 50 percent of the guns that turn up in crimes.’”

“Cuomo and Reed said their

Our Failure To Educate The American Public About The Uninsured

79% of Americans believe the government should pass legislation to address the issue of the uninsured but political support is substantially weakened because:

- only 28% knew that the number of uninsured is over 40 million.
- 47% falsely believe the number has decreased or stayed the same.
- 50% falsely believe most of uninsured are from unemployed families.
- 57% falsely believe they are able to get the medical care they need.

Source: “The Uninsured, The Working Uninsured And The Public,”
Health Affairs, Nov./Dec. 1999
Graph: RWHC 12/99

goal was a 'global settlement' not unlike that reached with the tobacco industry. And like the tobacco settlement, a general settlement with the firearms industry would not preclude smaller settlements involving particular companies and cities, they said."

"Any settlement talks probably would cover limits on how many guns could be bought at one time; better record-keeping, an independent monitor to see that safety regulations are enforced and better protection for children. 'You have safety caps on aspirin bottles, but not on guns?' Cuomo said. 'Where's the logic?'"

In A Shrinking World, AIDS Growth Chilling

From an editorial, "AIDS, the Worsening Catastrophe" in *The New York Times*, 12/5/99:

"Even though new drug therapies continue to cut AIDS death rates in wealthy countries like the United States, the news from the AIDS front is chilling. In the developing world, the situation is catastrophic. Even in the United States, where AIDS deaths have been declining, the spread of the AIDS virus continues unabated, with new infections accruing at roughly 40,000 a year for several years now. The only real gain is that drugs are helping the victims live longer. Infection rates are on the rise among minorities, women and young people as AIDS in this country becomes increasingly a disease of the poor and disadvantaged."

"A new report from the United Nations shows that this year AIDS is expected to kill a record 2.6 million people worldwide, higher than in any year since the epidemic began nearly two decades ago. More than 33 million people are infected with H.I.V. But these numbingly high numbers cannot begin to show the impact that AIDS is having on societies being ravaged by the disease. International aid agencies now consider AIDS a major obstacle to economic and human development."

"In sub-Saharan Africa, AIDS is single-handedly destroying the health and welfare advances of the last four decades. In some countries like Botswana, one in four adults is infected."

"Average life expectancy in southern Africa reached 59 years in the early 1990's but is expected to plunge back to 45 years in the next decade due to AIDS. Roughly half of the new infections in Africa are in people 25 years old or younger, who will typically die before their 35th year."

"The social impacts are staggering. More than 11 million children have been orphaned by AIDS since 1981, 95 percent of them in Africa. Soaring death rates among the young, who form a big share of the labor pool, will cripple economic development in many African regions."

RWHC - Eye On Health



"Not so sure he wanted to be remembered as having stood for the right to bear submachine guns."

"The industrialized nations up to now have provided less than \$500 million a year for international AIDS programs. Under the new budget signed by President Clinton, the United States will increase its contribution to global AIDS efforts to \$225 million for this year. That move is welcome. But the developed world needs to provide more leadership and resources to attack an epidemic that is overwhelming the world's poorest societies."

Illegal Drug Labs Invest Rural Wisconsin

From "State Law Enforcers Declare War on Methamphetamine Manufacture", Anita Clark, *Wisconsin State Journal*, 12/9/99:

"The dangerous, illegal drug is growing in popularity in Wisconsin, especially in the southwestern part of the state. Law enforcement people in Wisconsin are launching an attack against a dangerous illegal drug surging into the state."

"Methamphetamine labs and dump sites in southwestern Wisconsin have increased from two last year to nearly 30 this year, Attorney General James Doyle said Wednesday. 'Methamphetamine is not some clean, fun high that is a nice substitute for cocaine,' Doyle said. 'Methamphetamine is an extremely addictive drug and an extremely destructive drug.' Sold in pills, capsules, powder and chunks, methamphetamine produces angry, aggressive and violent behavior. The drug is surfacing in La Crosse, Green, Lafayette, Grant, Iowa, Crawford and Vernon counties."

"Flanked by legislators and representatives of merchant groups at a news conference that displayed

common, legal items used to manufacture the drug, Doyle listed three initiatives:

- Proposing a law that would make it a felony to steal anhydrous ammonia, a valuable fertilizer for farmers but a theft target for drug-makers.
- Helping store employees recognize suspicious customers who buy, for example, huge numbers of cold pills, lithium batteries and coffee filters.
- Educating people about the health/environmental dangers of methamphetamine manufacturing.”

“Small-town firefighters and police officers need to be aware that a meth lab ‘is not like a normal drug bust. You are going into a toxic situation,’ Doyle said.”

Mammography Task Force Update

The Community Physician’s Network (CPN) and RWHC have brought together a cross-section of hospital and clinic volunteers from across southern Wisconsin who are committed to developing a major intervention to improve our region’s very low mammography rates, first up to the state average and then, beyond that, closer to the desired benchmark.

An example of the challenge is illustrated by a story relayed to the CPN/RWHC Mammography Task Force by

a RWHC employee. Her 58 year old mother went for her first physical in several years; knowing we were starting this project, she asked her mother if she had asked for a mammogram, or was encouraged to have one; the answer was no on both counts.

The National Cancer Institute recommends that women in their forties or older get screening mammograms on a regular basis, every 1 to 2 years, and many authorities recommend that women over fifty should have a mammogram annually.

During the two year period of 1997 and 1998, only 45% of Wisconsin women over 65 years of age had had at least one mammogram paid for by Medicare compared to the current national goal of 60% (a rather conservative goal given the recommendation of annual mammograms for women over the age of fifty. Many counties in Wisconsin have a rate below 40%.

Centers for Disease Control & Prevention Barriers To Mammography Screening

Fear. Women may be afraid to discover that they have cancer.

Cost. Many women cite cost as the reason they do not use early detection programs. Many are not aware of the availability of low-cost programs.

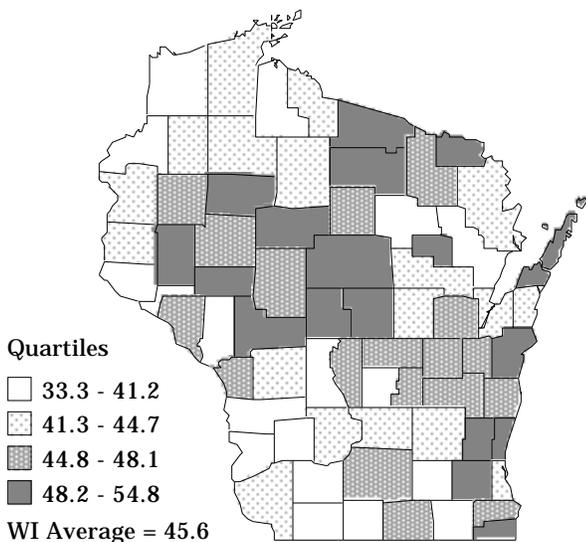
Lack of Transportation. For many women who lack transportation, convenient location of screening facilities is important.

Communication Barriers. Communication styles and methods appropriate for one group may be inappropriate for another.

Lack of Physician Referral. Studies have shown that women are more likely to be screened if their physician recommends screening.

Lack of Child Care. Some women need assistance with arranging child care to be able to use screening services.

Percent Women Over 65 Years of Age With at Least One Medicare Paid Mammogram in 1997 or 1998



Data: HCFA & Metastar, 12/99

Graph: RWHC 12/99

In addition to Barriers noted by the CDC in the box above, the Task Force mentioned the following issues as potentially also relevant to rural women:

- Lack of tracking mechanisms to highlight how an area or provider is doing compared to others.
- Lack of benchmarking with higher rate areas in WI (Marshfield, EauClaire)
- Limited evening and weekend hours available for local services.
- Shortage of personnel qualified to do mammograms.

- Concerns about level of local personnel's expertise.
- Lack of education regarding the need and benefits of regular mammograms.
- Less supportive community attitudes about mammograms.
- Hospital involvement in outreach for population based interventions is not routine.

The Task Force has begun conversations with the Marshfield Clinic to better understand what they have done in order to accomplish obviously higher regional rates. A partnership opportunity is seen with Metastar (the federally funded PRO for Wisconsin) who has in its current Scope of Work (SOW) a statewide goal of increasing mammography rates for Medicare eligible women. Additional partnerships with the Alliance and other regional health plans are also anticipated.

Racial Effects On Life Expectancy

From the University of Wisconsin, "How Fast Can the Racial Gap in Life Expectancy Between Whites and Blacks Be Eliminated?" by Hong Wang, Patrick L. Remington, and David A. Kindig from the e-journal *Medscape* at <www.medscape.com>:

"The racial gap in life expectancy between whites and blacks fluctuated from 7.6 to 5.7 years from 1970-1996, but the causes of this gap and the years required to eliminate it remain unclear. This paper analyzes the leading causes of death and how they contribute to the racial gap in life expectancy, and estimates the number of years required to eliminate this gap. The racial gap in life expectancy declined before 1982, increased from 1982 to 1989, and slowly declined after 1989. In 1996, about 54% and 62% of the racial gap was attributable to cancer, heart disease, homicide, and HIV for females and males, respectively. If blacks could experience substantial improvement in life expectancy, the current racial gap in life expectancy could be eliminated in about 40 years."

"Recent narrowing in the gap is primarily due to trends in homicide and HIV, and suggests progress toward eliminating disparity in prevention and control efforts. In fact, the trends in homicide since 1993, if sustained, suggest that the gap in life expectancy from this cause of death will be eliminated within a decade. Although

the gap in life expectancy due to HIV increased during the 1990s, it decreased from 1995 to 1996. More years will be needed to determine whether this encouraging trend will persist in the future and further contribute to a narrowing of the overall gap in life expectancy."

"The years required to eliminate the overall racial gap in life expectancy derive directly from assumptions regarding trends in cause-specific mortalities by race. The past 26 years have shown both favorable and unfavorable trends that could be the basis for prediction. Our own prediction of about 40 years is primarily based on the state and international experience of an overall decrease of 0.1-0.2 years per year in racial gap in life expectancy. While some states had higher levels than this (maximum 0.24), many had lower ones. The trends in the gap from homicide and unintentional injury in the past 2-3 years and HIV in the last year certainly foster optimism, but it is unlikely that such steep rates of decrease could be maintained."

"It is not our purpose nor do we have adequate data to explain the causal factors producing these racial disparities. We believe that much of the gap is attribut-

able, not to race per se, but to nonmedical determinants of health, such as income, social class, and the environment. However, disparities in access to medical care and preventive services are undoubtedly important as well. There is a great need for additional research, which will unravel these complex and causal relationships."

Black/White Life Expectancy Gap United States, 1996

Causes of Death	Gap (yrs)	%
Cancer	1.22	15.7
Heart disease	1.21	15.6
Homicide	1.2	15.4
HIV	1.19	15.3
Cerebrovascular	0.3	3.9
Unintentional injury	0.26	3.3
Diabetes	0.21	2.7
Suicide	-0.13	-1.7
Other causes	2.46	31.6
Residual	-0.14	-1.8
Total	7.78	100

Data: Wang, Remington, Kindig, 9/99
Graph: RWHC 12/99

The Wheelchair-Part I

From "Of Wheelchairs and Managed Care" by Andrew Batavia, *Health Affairs*, .Nov./Dec., 1999:

"After twenty-five years of living with high-level quadriplegia, I was familiar with the routine. Every five or six years my wheelchair-repair person would tell me that my chin-controlled motorized wheelchair was getting old and could be expected to break down with increasing frequency in the coming year. I would then ask my primary care physician to write a prescription for a new motorized wheelchair using the precise specifications I provided, send the prescription to my insurance company, and prepare for battle. I never looked forward to the kabuki dance that would follow, but I was able to endure it, content in the knowledge that I would ultimately prevail and obtain the wheelchair I needed to maintain my independence and employment."

"However, last year the routine changed. I had the same conversation with my wheelchair-repair person. I presented the same list of specifications to my primary care physician, and I was prepared to take my combat position in the epic confrontation with my preferred provider organization (PPO), Blue Cross and Blue Shield (BCBS) of Florida. However, this time I found that the battle lines and alliances had changed. For the first time in my life as a person with a disability, my primary care physician refused to write the prescription. For the first time I was not certain whether I would be able to obtain the wheelchair I needed."

"Before shouting 'Treason,' I decided that rationally I should attempt to learn why my doctor refused to write the prescription or, as I perceived it, refused to open the gate between me and my new wheelchair. I was hoping for a simple, innocuous explanation. For instance, he had already written too many prescriptions that day and was experiencing 'prescription burnout' (a new psychiatric diagnosis under the *Diagnostic and Statistical Manual of Mental Disorders*). And if I just came back the following day he would write it out. Unfortunately, the situation proved to be far more complicated than that."

"When I confronted my physician directly with this issue, he responded that he did not know anything about motorized wheelchairs, and that I should talk to his office manager who had spoken to a BCBS representative. My conversation with the office manager, from which I still have not fully recovered, went something like this:

Me: I am very disturbed that Dr. Harris will not write a prescription for my new chair, Ms. Johnson. My current chair is falling apart.

Ms. Johnson: I spoke with a representative from your PPO, who informed me that they are willing to pay for the repair of your chair but not for a new one.

Me: But each time it needs to be repaired I won't have the use of it. My wheelchair-repair person has informed me that my current chair is at the end of its useful life and breakdowns are likely to become more and more frequent. Every time it breaks down, the effect on me is similar to as if your legs just stopped working. I can't work, I can't pick up my kids from school, and it could be hazardous if the chair breaks down in the middle of a street.

Ms. Johnson: I am just telling you what your company told me.

Me: Okay, if that's the case, why don't you just give me the prescription and I'll fight it out with the PPO.

Ms. Johnson: The doctor won't write the prescription for you.

Me: Why not?



Ms. Johnson: How are we to know if you really need a new chair or if the current chair can still be fixed? If we were to write the prescription, and you do not really need a new chair, we could be subject to claims of health care fraud.

Me: I teach health care law. It's extremely unlikely that you would be subject to such claims if you indicate in good faith that I am a quadriplegic with a wheelchair that is over five years old and in growing disrepair.

Ms. Johnson: We do not know if the chair can still be fixed.

Me: Any piece of equipment can still be fixed. The question is whether it's worthwhile doing so. Your car could be fixed indefinitely, but you probably wouldn't want to have to rely on it if it were in the repair shop half of the time. How would you get to work? I have the same problem with my wheelchair.

Ms. Johnson: Do you know how much this new wheelchair will cost? About \$24,000. We all end up paying for that. The company has a right to decide whether a new chair is needed or whether the current chair can be repaired.

Me: First, I know how much the chair will cost. It is a highly customized, sophisticated piece of equipment. Do you think I am happy about its price? I'll have to pay about 20 percent of that cost in deductibles and copayments. That's a substantial amount of money out of pocket, and I can assure you that I would not order this chair unless I absolutely needed it. Second, you are right that it is for the company to decide, not you. Now, will you ask Dr. Harris to write the prescription?

Ms. Johnson: No, I won't. You can have your current chair repaired.

Me: Why do you think you know so much about my chair? How do you know that my chair can still be repaired productively?

Ms. Johnson: My grandmother is in a similar chair.

Me: Your grandmother must be a high-level quadriplegic. How unusual! There are only a few customized chairs like mine in the country, and she has one of them."

"The decibel level of this discourse rose as the discussion grew more and more bizarre. Toward the end it became clear that this doctor's office would not resolve the dilemma."

"Why was my primary care physician effectively abandoning me in my effort to get a new wheelchair? Maybe he really believed that writing this prescription without having better knowledge of wheelchairs constituted fraud. More likely, he was afraid to anger the PPO by authorizing an expensive wheelchair that the PPO would have to pay for. Perhaps he was concerned that there would be negative repercussions such as being removed from the provider network, which could affect his livelihood. Whatever the actual reason, I was incredulous that my own primary care physician would not write me a prescription for my wheelchair."

to be continued next month

Beyond Rural, Beyond Frontier, Is Jungle

A new feature in *Eye On Health* will be periodic excerpts of letters from Dr. Linnea Smith who works at the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. Dr. Smith treats about 2,400 patients a year, all arriving by dugout canoe or on foot. Services include family medicine, prenatal care and birthing, dental care, treatment of snakebite, cholera, parasites, infectious diseases, malaria, and trauma.

Dr. Smith's long-term goals are to expand the clinic's services, to encourage preventive medicine, and to promote medical services in other remote areas. Dr. Smith is a 1984 graduate of the University of Wisconsin-Madison Medical School and is board-certified in internal medicine. She practiced in Prairie du Sac, WI from 1987-1990 when she moved to Peru.

Late November, 1999. Dear all and everyone:

"When I last wrote, I had just gotten off the boat at Yanamono, so we'll pick up from there Returned to Yanamono to find house, cat, clinic, and all, still stand-

University of Wisconsin Medical School Seeks Rural and Community Health Leadership

RWHC is working with the U.W. Medical School in its search to fill the newly created position of Assistant Dean for Rural and Community Health. This individual will also staff the Medical School's soon to be formed rural health advisory board.

The Medical School's goal is, for the first time to develop and support, an integrated strategy for rural and community health programs associated with the University of Wisconsin Medical School.

The Assistant Dean for Rural and Community Health will provide administrative leadership for the implementation of the Medical School's strategic plan for rural and community health. He or she will provide leadership in rural and community educational program development. This position will provide leadership and coordination with the four Regional AHEC Centers and the AHEC Statewide Partnership Council and the UWMS Office of Rural Health. The Director will work closely with senior administrative leaders at the UW Medical School and other health profession schools, and will be a liaison to key external organizations that are involved in rural and community health program development.

Nominees should have experience in development and management of community education programs and a strong interest in interdisciplinary education. For additional information, contact Margie Martin at <msmartin@facstaff.wisc.edu>.

ing and approximately healthy. The house had been slightly invaded by some buggardly termites who took advantage of my prolonged absence to build themselves a Dutch-oven-sized nest in the corner above the mirror. This is the first time they have had the nerve to actually construct nests inside the house; normally it is just their tunnels that I have seen.

"However, the new nest was removed, and the invaders scoured with Actelic, a potent but allegedly safe-to-humans-and-cats insecticide. Unlike some cats, Otorong holds no grudges, and when I called to her as I came up the path to the house, she immediately forgave me for my unconscionably long absence and began rubbing against the house steps and purring and generally making me feel welcome."

"I began my first full day back at the clinic alone (after a trip back to Wisconsin). This virtually guaranteed a busy day, but in case I had any doubts, they were banished when the first patient knocked on my door at 5:30 a.m. This was a three-month-old infant (it was actually his distraught parents who knocked) who had allegedly been sick only one day with a fever. It was

Childhood Immunizations: Improving Your Rates

Target Audience: Anyone responsible for assuring that children have their full compliment of immunizations

RWHC, Sauk City, Thurs. Jan. 13th, 9:30 am to 2:00 pm

No charge for one registrant. Contact Jessica Vande Hey at 608-643-2343 or <jvandehey@rwhc.com>.

Supported by: WI Rural Zones of Collaboration Initiative

an infection of the bloodstream, and that very likely he had been sick for longer than one day and his parents simply did not want to admit that they had delayed coming for help. Then again, who knows? Infants are susceptible creatures, and perhaps he really only was sick for a single day. In any case, it hardly matters now. The rest of the week remained busy. The malaria outbreak has calmed down. We recorded 53 cases of malaria in July, 23 in Aug., 5 in Sept., and only 3 in all of Oct."

clear at first glance that the child was in a bad way. He indeed had a fever, but not much else - no cough nor glunky-sounding lungs which would have signified pneumonia, no stiff neck or lethargy or bulging fontanelle which would have suggested meningitis, no seizures, no obvious dehydration. But he was breathing very rapidly and fairly loudly, and his breathing and his feeble cries had a desperate sound."

"I confirmed that there was nothing any more specific than this on exam, gave an injection of a potent antibiotic, and instructed his parents to meet me at the clinic at eight. When they did so, I found that the baby hadn't improved at all; in fact his fever was a little higher. I shook my head, put the child on oxygen, and told the parents that it didn't look good. As he struggled to hold on to life through the morning, fifteen other patients came in, for a variety of illnesses ranging from malaria to family planning (not an illness!), to acute diarrhea (four cases; as the water begins to come up in the river, all the junk is washed off of the banks and into the drinking water), tooth decay, and one case of possible hepatitis. When I went to lunch at mid-day, the infant showed no improvement, and when I returned in the afternoon, the child had died."

"In the U.S., of course, bloodwork would have been drawn, and an autopsy would have been performed; here, all I could say was that it was probably sepsis,

*The clinic operates with grass roots support from family and friends and many others. **AMP is a non-profit, tax-exempt organization. Donations are welcomed c/o: Amazon Medical Project, Inc., 5372 Mahocker Rd., Mazomanie WI 53560.** All contributions directly support delivery of medical services; administrative services are donated by family and friends. Volunteer physicians, PAs, and nurse practioners are welcomed. Individuals must speak Spanish. Lodging is provided by Explorama Lodge at discount rates. For more information contact Dr. Linnea Smith through AMP.*

RWHC Seeks EMS Consultant

RWHC is soliciting proposals for as many as nine assessments of local rural community Emergency Medical Service systems. Proposals must be received by Noon, Monday, January 24th, 2000. The successful bidder will be notified on or before February 15th and the work must be completed before July 1st, 2000. The complete RFP is available at <www.rwhc.com>.

The Bureau of Quality Assurance (BQA) of the Wisconsin Department of Health & Family Services (Department) has received a grant from the federal Health Research Service Administration's Rural Hospital Flexibility Program to facilitate small rural hospitals, who so choose, to seek designation as Critical Access Hospitals (CAHs). A portion of the grant has been set aside for RWHC to enter into contracts to provide consulting or technical services to nine hospitals in the 1999-2000 grant period. One such collaborative approach is for assessment and planning of upgrade of local emergency medical services.

Levels of emergency medical services vary considerably in rural Wisconsin. Under the Rural Hospital Flexibility Program, hospitals that apply for a critical access hospital status are required to identify their ambulance service provider resources, i.e., the number and type of personnel, equipment, communication capability, etc.. They must also enter into formal agreements regarding their services and identify back-up resources. CAH hospitals must be able to describe fully how the communication with on-call doctors, physician assistants or nurse practitioners will work, or how the hospital will assure ready access on a 24-hour basis.

RWHC - Eye On Health



"Government's job is to collect taxes and pay us;
our job is to spend them as we feel best."