

Review & Commentary on Health Policy Issues for a Rural Perspective – September 1st, 2009

Rural Faces Reform Hard Hit by Recession

From “The Financial Effects of Wisconsin Critical Access Hospital Conversion, August, 2009” by Dale Gullickson and Rich Donkle at RWHC with funding and support from the Wisconsin Office of Rural Health as well as assistance from the Wisconsin Hospital Association and the Wisconsin Department of Health and Family Services. The complete 40+ page report will soon be available at www.rwhc.com :

“One of the main objectives of the Critical Access Hospital (CAH) program was to improve the financial stability of small, rural facilities. These facilities were struggling with Medicare’s Prospective Payment Systems (PPS). Medicare payments to these institutions were inadequate because they did not take into account low volumes and higher fixed costs. The financial deterioration of the hospitals resulted in a lack of capital investment. Some facilities closed. Lack of access to healthcare services became an issue in some areas. Currently, CAHs are paid 101% of their Medicare costs for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds. As a result, prior studies have shown that the CAH program has improved financial performance and access to capital.”

“This study shows in spite of prior improvement, the financial strength of Wisconsin

CAHs in 2008 is again significantly lower than the state average.”

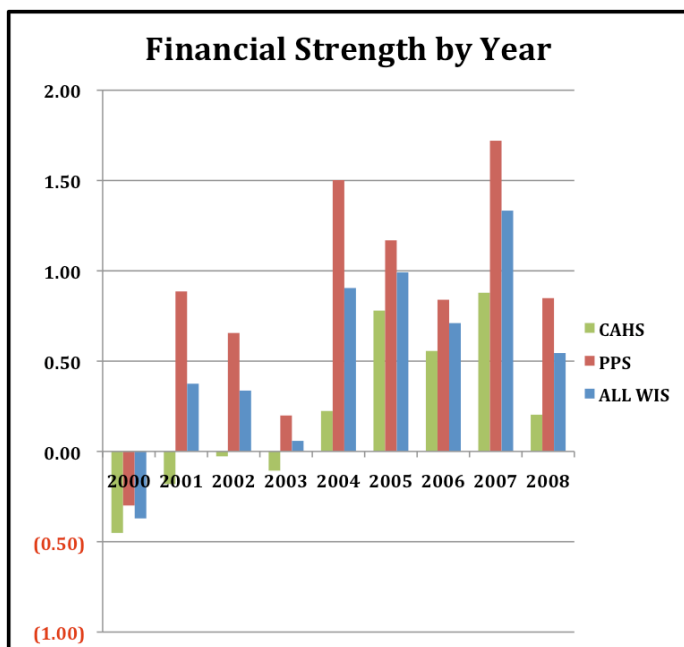
- “CAHs experienced lower operating margins than PPS hospitals in 2008,” (3.6% compared to 5.9%).
- “CAH and PPS total margins both dropped to about 4%,” (due to PPS larger investment losses.)
- “Overall strength as measured by the Financial Strength Index decreased in 2008 for all hospitals,” (with CAHs about one-third of that for PPS.) See the chart below.
- “CAHs average age of plant declined in 2008 but still is higher than PPS hospitals;” (higher is worse as buildings and equipment are older.)
- As CAHs struggle with lower margins, they “are discontinuing services such as nursing homes, chemical dependency and psychiatric units.”

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“.. in sickness.. in recession and with or without health reform.”

“2008 was a challenging year for all hospitals due to economic conditions, but the gap between CAHs and the state average increased. Capital investments (as measured by the average age of plant ratio) for CAH’s improved in 2007 and 2008 but remains worse than the state average. Operating margins for CAHs in 2008 were significantly lower than the state average. PPS hospitals, with relatively larger investment portfolios, had larger non-operating investment losses so the 2008 Total Margin for both CAHs and PPS were the



same. The number of CAHs providing services such as nursing homes, psychiatric units, chemical dependency care and home health services have decreased. One reason for this trend may be the negative financial impact the services have on the organization as a whole. Several key utilization statistics such as inpatient days, surgical operations, and emergency visits all showed less growth or more rapid decline in 2008 from 2007 for CAHs than experienced by PPS hospitals.”

“The purpose of this study is to analyze the financial condition of Wisconsin’s Critical Access Hospitals (CAHs). This report updates previous studies completed in 2003, 2005, and 2007. There have been many changes in the healthcare industry since 2007.

RWHC Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979, has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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Changes in Federal and State government programs, increasing competition, consumer-driven transparency and an economic downturn have happened since the last CAH study.” **Proposed new State of Wisconsin Medicaid cuts focusing on CAHS will further weaken their financial condition.**

Debate Beyond the Lunatic Fringes?

From the commentary “The mob scenes surrounding ‘town hall’ meetings with Congressmen and Senators haven’t disappeared, but common sense seems to be rearing its pretty head” by Bill Wineke, 8/13/09 at <http://www.yournews.com/> :

“The worst thing about Americans is that they all too easily believe their leaders want to kill them.”

“The best thing about Americans is that, after making fools of themselves, they will often settle down and do the right thing.”

“For a few days, it looked as if gangs of hoodlums would march through town halls around the country, shouting down elected representatives and terrorizing those who support health care reform. Congressmen were receiving death threats. One guy even carried a loaded handgun in a holster to a town hall meeting held by President Obama.”

“Right wing talk show hosts had field days supporting the craziest of the crazies. Rush Limbaugh announced that the Democrats were quite a bit like the Nazis.”

“But, by mid-week, the tenor of the meetings changed just a little. Sen. Claire McCaskill held a town meeting in Missouri that went on for more than two hours. People shouted and jeered her defense of health care—but they stuck around and she was at least able to make her points. The same thing happened to Sen. Benjamin Cardin in Delaware.”

“It’s not that the meetings suddenly became examples of civil discourse. We don’t really do civil discourse well in this country. People have a constitutional right to yell at their elected representatives and there are real questions to debate as Congress develops a national health care policy.”

"It is only when mobs take over public meetings and use them to threaten their lawmakers that things seem unAmerican. And unAmerican is pretty much the way those early town halls looked. Now the anti-Obama zealots still have their rants, but the rants aren't the only things heard in the hall. This is a good thing."

"As for those who truly fear that Obama will change Medicare so that the elderly are encouraged to die, there's just one answer that makes sense: Why do you think President Obama would do such a thing?

He is an elected politician, a fallible human being, to be sure, but an elected politician. Elected politicians don't go around demanding their constituents die."

"You don't have to agree with his policies. You don't even have to trust his honesty. All you have to ask yourself whether it makes sense that any politician would ever endorse such a crazy idea? Politicians are timid people. They don't encourage euthanasia among the nation's most ardent voting group."

From "Civility reins at Kind's town hall meeting" by Bill Glauber, Journal Sentinel, 8/18/09:

"Maybe it was the ground rules: no signs, no disruptions and no long-winded speeches." Maybe it was the location: a small city far from a big media market. Or maybe it was the simple fact that several hundred people gathered at the tidy Richland Center Community Center with the intention of actually listening to one another and their elected representative on the emotive issue of health care."

"Whatever the reason, Tuesday, U.S. Rep. Ron Kind was able to lead a town hall meeting that was passionate, informative and, for the most part, civil."

"This is what we've been encountering in most of my public forums," said Kind, a La Crosse Democrat. "I don't know if it's homegrown Wisconsin civility. Obviously, passions run deep on both sides of the health care discussions. There was enough respect and courtesy where you can conduct a forum of this nature without degenerating into mob rule."

"The standing-room-only crowd was so polite that nobody in the audience asked Kind whether he planned to run for governor."

RWHC Eye On Health



"You're too dumb to understand why I'm right and you're wrong, even if I could explain it."

"Once we get beyond the craziness, we can look at the serious questions involved in health care reform. We can ask just how such a grand program can be paid for using the criteria the president proposes. We can ask whether there is as much 'waste' in the system as the president thinks there is (answer, yes there is but rooting it out will not be as simple as he makes it sound)."

"One thing is clear: There will be health care reform. There will be health care reform because the Democrats made reform a central theme of their

campaign last year and they won not just the presidency but overwhelming majorities in the House of Representatives and in the Senate. If they don't pass health care reform, they are toast and they know it."

"The question is whether those who have a sincere interest in doing it right will be heard in the deliberations or whether the lunatic fringe of the Republican Party raises such noise that reasonable voices will be drowned out and the bill will be passed biased toward the lunatic fringe of the Democratic Party."

"The jury is still out, but it seems to me that common sense is once again rearing its pretty head. We'll see."

Co-ops Neither Stupid Idea Nor Magic Bullet

Due to political posturing and expediency there has been a lot of misinformation in the media both pro and con the development and use of cooperatives in America. To set the record straight:

What are cooperatives? "A cooperative is a business that is owned and controlled by the people who use and benefit from its services. The time-honored co-op principles include: voluntary membership, one vote per member, equitable distribution of profits, member commitment and investment, commitment to education and cooperation among cooperatives."

Above from “The History of Cooperatives in Wisconsin” by Greg Lawless at www.wisconsinstories.org/

Why do people start cooperatives? “For 150+ years, cooperatives have been an effective way for people to exert control over their economic livelihoods. Cooperatives continue to have a powerful impact on Wisconsin’s economy. Today, in an era when many people feel powerless to change their lives, co-ops represent a strong and viable economic alternative.”

“Co-ops are formed to meet peoples’ mutual needs. They are based on the powerful idea that together, a group of people can achieve goals that none of them could achieve alone.”

“There is a rich history of cooperation in our state and country. In Wisconsin, 2.7 million residents (more than half the population) are served in some way by cooperatives.”

“Cooperatives in the U.S. play a vital role in the economy. Over 47,000 cooperative businesses generate \$100 billion in economic activity. Nearly 40% of the U.S. participates in some kind of cooperative.”

From “Cooperatives: A Tool for Community Economic Development, Chapter 3.” University of Wisconsin Center for Cooperatives, www.uwcc.wisc.edu/

Future Workforce Crisis a Global Challenge

From “A slow-burning fuse” in the *Economist*, 6/25/09 at www.economist.com/ :

“Stop thinking for a moment about deep recession, trillion-dollar rescue packages and mounting job losses. Instead, contemplate the prospect of slow growth and low productivity, rising public spending and labour shortages. These are the problems of ageing populations, and if they sound comparatively mild, think again. When the International Monetary Fund earlier this month calculated the impact of the recent financial crisis, it found that the costs will indeed be huge: the fiscal balances of the G20 advanced countries are likely to deteriorate by eight percentage points of Gross Domestic Product in 2008-

RWHC Eye On Health, 8/20/09

09. But the IMF also noted that in the longer term these costs will be dwarfed by age-related spending. Looking ahead to the period between now and 2050, it predicted that ‘for advanced countries, the fiscal burden of the crisis [will be] about 10% of the ageing-related costs.’ The other 90% will be extra spending on pensions, health and long-term care.”

“The rich world’s population is ageing fast, and the poor world is only a few decades behind. According to the United Nation’s latest biennial population forecast, the median age for all countries is due to rise from 29 now to 38 by 2050. At present just under 11% of the world’s 6.9 billion people are over 60. Taking the UN’s central forecast, by 2050 that share will have risen to 22% (of a population of over 9 billion), and in the developed countries to 33%. To put it another way, in the rich world one person in three will be a pensioner; nearly one in ten will be over 80.”

“This is a slow-moving but relentless development that in time will have vast economic, social and political consequences. As yet, only a few countries with already-old populations are starting to notice the effects. But labour forces are now beginning to shrink and numbers of pensioners are starting to rise. By about 2020 ageing will be plain for all to see. And there is no escape: barring huge natural or man-made disasters, demographic changes are much more certain than other long-term predictions (for example, of climate change). Every one of the 2 billion people who will be over 60 in 2050 has already been born.”

“Fewer hands make heavy work”—Macroeconomic theory suggests that the economies of ageing populations are likely to grow more slowly than those of younger ones. As more people retire, and fewer younger ones take their place, the labour force will shrink, so output growth will drop unless productivity increases faster. Since the remaining workers will be older, they may actually be less productive.”

“In most rich countries the ratio of people of working age to those of retirement age will deteriorate dramatically over the next few decades. In Japan, for instance, which currently has about three workers to every pensioner—already one of the lowest ratios anywhere—the number will halve by 2050. True, there will be fewer young people to maintain, but children cost less than old people and the overall burden



will be much heavier than it is now. The Organisation for Economic Co-operation and Development has estimated that over the next three decades the age-related decline in the labour force could cut growth in its member countries by a third compared with the previous three decades.”

“Ageing will affect financial markets too. According to Franco Modigliani’s and Richard Brumberg’s lifecycle theory of savings, put forward in the early 1950s, people try to smooth out their consumption over the course of their lives, spending more in their youth and old age and saving more in their middle years; so as populations age, savings in the economy as a whole will be run down and assets sold off.”

“This has led to fears of an ‘asset meltdown’ as everyone sells at the same time. But a number of academic studies have so far failed to find much evidence of this. Older people in America, for instance, do save less than those in their middle years, but as a group not much less.”

“James Poterba, an economics professor at the Massachusetts Institute of Technology, says America has three kinds of retirement households: the least well-off, perhaps a quarter of the total, who will maintain something close to their previous standard of living on Social Security and Medicare, even with few savings; the richest 10-15%, who hold significant assets and may not need to draw them down; and the large majority in between, who will have to rely on their own, often inadequate, savings in retirement.”

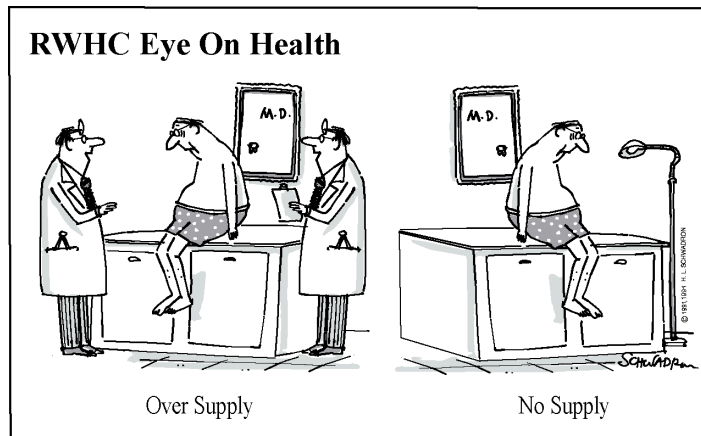
“For the public finances, an ageing population is a huge headache. In countries where public pensions make up the bulk of retirement income, these will either swallow up a much larger share of the budget or they will have to become a lot less generous, which will meet political resistance (older people are much more inclined to vote than younger ones). Spending on health, which in most rich countries has been going up relentlessly anyway, is likely to grow even faster as patients get older. And because of a huge increase in the number of over-80s, a lot more

money, and careful thought, will be needed to provide long-term care for them as they become frailer.”

“What can be done? As the IMF puts it, ‘the fiscal impact of the [financial] crisis reinforces the urgency of entitlement reform.’ People in rich countries will have to be weaned off the expectation that pensions will become ever more generous and health care ever more all-encompassing. Since they now live so much longer, and mostly in good health, they will have to accept that they must also work longer and that their pensions will be smaller.”

“Will the recession make it easier or harder to introduce the required reforms? If people are feeling poorer, they may think that their government should do more for them, not less. Yet some say that if everything is in a state of upheaval already, change becomes easier to bring

about. They cite a phrase currently much used in the Obama White House: ‘Never waste a good crisis.’ ”



Federal View on Rural Healthcare Workforce

From “Workforce and Community Development” in the *2009 Annual Report by the National Advisory Committee on Rural Health and Human Services*; the complete report also addresses rural medical homes and can be found at <http://ruralhealth.hrsa.gov/> :

“The Committee’s research over the past several years has demonstrated that there are many factors which have set up a perfect storm for a rural workforce crisis. The rural workforce shortage ultimately affects all other health and human services delivery, as is reflected in each chapter of this report. Health and human services workforce development is interconnected with community development. **In rural communities, this relationship is a self-reinforcing cycle: a strong health and human services presence contributes to the overall well-being of a community and health of the residents, just as economically stable and strong, viable communi-**

ties are more effective in recruiting and retaining health and human services professionals. The Committee has noted over the years that strong local leadership development programs can provide the training needed for rural residents to develop successful collaborations in rural communities.”

“Collaboration needs to occur at the community level between appropriate stakeholders, which may include community and technical colleges, local workforce boards, local employers and the local government. Ultimately, workforce development would be a shared responsibility between the Federal, State, and local government across health and human services, labor and education to provide an adequate health and human services workforce for each community. The Committee believes that Federal programs at HHS and DOL need to be designed to foster and support this collaboration.”

Recommendations—“The Secretary should develop data tracking systems for the health and human services workforce. Based on this data, the Secretary should target resources and develop training programs for professions in ‘high-need’ geographic areas.”

“The Secretary should work with Congress to secure additional funding for allied health training programs within Title VII of the Public Health Service Act.”

“The Secretary should work with Congress to amend the Title VII authority to allow greater discretion over how to allocate funding for different health professional needs over multi-year periods.”

“The Secretary should work with Congress to secure additional funding for the Nursing Loan and Nursing Scholarship programs under Title VIII of the Public Health Service Act so that existing nursing programs can better address current workforce shortages.”

“The Secretary should use Section 301 authority under the Public Health Service Act to support demonstration grants for creative, community-based workforce training programs that address local geographical and financial constraints and are targeted towards rural communities through Critical Access Hospitals, Rural Health Clinics and Federally Qualified Health Centers.”

Wisconsin View on Healthcare Workforce

The following is from the white paper, “Wisconsin’s Urgent Need for Collaborative Health Workforce Planning, a statement of the Wisconsin Department of Workforce Development’s Select Committee on Healthcare Workforce developed by the Wisconsin Health Workforce Data Collaborative,” 6/29/09; the complete paper is available at www.rwhc.com :

“For several years, health care analysts and economists have been predicting massive and growing shortages of health workers in the United States. According to a new Institute of Medicine publication, *Retooling for an Aging America: Building the Health Care Workforce*, the United States will need an additional 3.5 million health care providers by 2030 just to maintain the current ratio of providers to the total population. This is a 35% increase over current levels.”

“An article on health care workforce by Daniel W. Rahn and Steven A. Wartman in the November, 2007 issue of the *Chronicle of Higher Education* further makes the case that we are facing a crisis: ‘The United States faces a looming shortage of many types of health-care professionals, including nurses, physicians, dentists, pharmacists, and allied-health and public-health workers. The results will be felt acutely within the next ten years. Colleges and health science programs will all be affected by demographic, technological, and bureaucratic trends driving the pending crisis. **The final crucial factor precipitating the health care workforce crisis is a lack of comprehensive workforce planning on the parts of academe, government and health care professions.**’ ”

Health workforce data analysis (including collection) and forecasting is necessary to develop an effective response to the health workforce shortage threatening our most vulnerable communities. A healthy state requires a sufficient, diverse, competent and sustainable health workforce. The public’s health is dependent upon an adequate supply of personnel in all health settings: public health, hospitals, primary care practices, specialty care, long term care, home care, pharmacies, dental care facilities, mental health facilities, rehabilitation and a variety of other support service settings.”

“Effective health workforce planning and development requires the ongoing collection and analysis of supply, demand and distribution data. This work necessitates a public-private partnership.”

“Health professions’ educational programs, employers and public agencies in Wisconsin have been unable to obtain workforce data and labor market projections adequate to inform decisions regarding the preparation, retention and distribution of a sufficient health workforce. Efforts to gather and analyze data on labor markets and distribution of health professionals are uneven and we need suitable models for forecasting supply and demand in the health sector on the state and local level.”

“Consequently, educational programs training health occupations struggle to determine the number of prospective students to be admitted based on future projections of need in Wisconsin. Employers of the health workforce in Wisconsin struggle to obtain workforce data and labor market projections adequate to inform decisions about the number of health professionals who are entering and exiting the workforce. Prospective students (and their parents) struggle to determine the health occupations to select based on forecasted job availability.”

“Statewide estimates aren’t enough. As said more than once about workforce shortages during the development of this project: ‘when it starts raining in the suburbs, expect a tsunami in Wisconsin’s rural and inner-city communities.’ Our education and vocational programs in all of the disciplines need the data to ‘Mind the Gap’ between supply and demand, not just in terms of state averages but also in terms of the local reality of our many diverse communities.”

“All of Wisconsin’s health workforce related sectors must rapidly move forward on a number of fronts:

- **Recognize the urgency for health workforce data analysis (including collection) and forecasting to maximize the use of limited public/private funding for workforce development.**
- **Recognize the importance of collaborative workforce planning. Multiple key stakeholders each bring different perspectives on workforce needs and different resources that are critical to**

defining the problems and developing strategies to address them.

- **Recognize that the health care workforce will particularly, if not uniquely, be affected by the large baby boomer cohort increasingly aging out of providing health care into consuming it, accelerating the divergence between supply and demand.**
- Assure that we have the accurate data necessary to describe the current state of our health workforce and its shortages, as well as to allow forecasts of what we are likely to face in ten to fifteen years. The health care workforce is particularly dependent on individuals requiring extended post-secondary education.
- Create the capacity to make forecasts that are sensitive to changes in practice models and emerging professions. Develop forecast tools capable of accommodating multiple scenarios (e.g., various assumptions about the economy, health care system reform, practice models and shifts in demand into population and public health sectors.)
- Commit, within and among disciplines, to statewide planning to reconcile the aggregate effect of decisions made by individual schools and the forecasted need for a diverse array of professionals and health workers under various future scenarios.
- In particular, replicate and expand on the multi-school collaboration and planning that has been accomplished in Wisconsin such as the University of Wisconsin’s *2008 Nursing Education Task Force Report* and the *2007 Report from the Wisconsin Nurse Faculty Task Force*.
- Address variation in supply and demand across regional, urban and rural labor markets.
- Utilize nationally agreed upon data sets where they have been developed (e.g., nursing, pharmacy, public health and long term care).
- Recognize the need for a diverse workforce with the cultural and linguistic competence to improve the delivery of care for all populations.

- Encourage different health training programs to track and share data relevant to applicants, students, graduates and faculty (e.g., full-time/part-time, age, number of graduates, graduate retention in the state and distribution, time to get through school, time to get jobs after graduation as well as faculty numbers and ages).”

“In addition to the above, we need our major post-secondary academic institutions to address the following:

- Bring together substantial academic resources in health policy, economics, demography and related fields to work in partnership with key state stakeholders to research issues related to the state-wide health workforce crisis and inform the policy-making process.
- Advance the need for a standardized Wisconsin database with uniform definitions to describe the core characteristics of applicants, students, graduates and faculty.
- Work towards a common statewide standard set of definitions.

- Work towards greater alignment of curricula across campuses to streamline students’ ability to move their educational attainments.
- Partner to allow for successful articulation from associate degree to bachelor prepared graduates.
- Work towards greater alignment of academic calendars within the state to facilitate partnering with sites offering student clinical placements.
- Work with state stakeholders including the Wisconsin Health Workforce Data Collaborative on a collective vision for a comprehensive program for health care workforce data collection, analysis and forecast modeling of future scenarios, available to all academic planners, health care employers and policy makers.”

RWHC Blog: “The Rural Health Advocate”

Have you every wanted to speak back to this newsletter? Now you can—selected editorials and cartoons are now inviting both opposing and supporting comments at:

www.ruraladvocate.org/

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