

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2008

Reform Needs Renewed Sense of Community

It is the time to revisit a classic; from “The Excesses of Individualism, for Meaningful Healthcare Reform, the United States Needs a Renewed Sense of Community” by Charles Dougherty in Health Progress, Catholic Health Association (www.chausa.org/), 1/92:

“In the United States at the end of the twentieth century, the balance of values tilts too far toward the individual and away from the community. What is needed is a renewed sense of community that enhances the lives of individuals as it serves the common good. The first step toward creating a new balance is a critique of the present imbalance, which is shaped by excessive forms of individualism that affect every aspect of our healthcare delivery system.”

“Technological individualism occurs when the value of technology is measured only by its service to the individual. The results are a technological imperative, unreasonable expectations on the part of the community, distorted judgment on the statistical likelihoods of individual outcomes, fragmentation of care, and a reliance on rescue medicine.”

“A psychosocial individualism has misshapen our attitudes about ourselves and our communities, bringing with it a deepening sense of alienation. The re-

sults in U.S. healthcare include commercialization, exclusion of the poor, a litigious provider-patient relationship, declining respect for life, and a sense of community that excludes other generations and nations.”

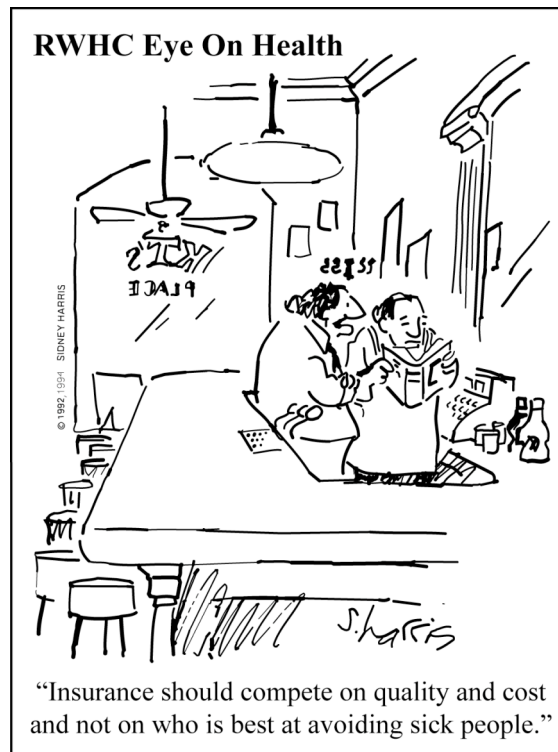
“Libertarian individualism has created political isolation and prevents the evolution of democratic decision making and real partnerships in healthcare. The

results are an unpooling of insurance risk, an interpretation of freedom that is inimical to family and community ties, hostility to government, a view of healthcare as a commodity, and deprofessionalization of the medical professions.”

“Healthcare reform must seek to change what medical technology does for us, repair the psychosocial harms healthcare individualism has produced, and promote citizen participation in the healthcare system in new and important ways.”

Commercialization – “U.S. healthcare places less emphasis on mission and more on

margin; less emphasis on the needs of others, more on self-interest. Large parts of the delivery system have become commercialized. Many hospitals whose founding intentions were based on compassion for the sick, especially for the sick poor, are now operated like businesses and are expected to generate sizeable margins. In the 1980s, as investor-owned, for-profit hospitals spread throughout the United States, the traditional moral notions that profit should



not be made on the illnesses of others and that commercial competition in healthcare is inappropriate began to break down. Some institutional providers that are technically not-for-profit are as margin driven and competitive as their for-profit peers. Pharmaceutical houses and manufacturers of medical technology and supplies make exceptionally high profits. Healthcare is a major focus of investment in the stock and bond market, and philanthropy to hospitals has all but disappeared.”

“Individual providers have been affected, too. Physicians, nurses, and other healthcare professionals provide significantly less charity care than they did a generation ago. Doctors’ investments in preferred provider organizations, imaging centers, and other new sites for testing and treatment have provoked government scrutiny. Clinical research has been probed for conflicts of interest. Pharmaceutical companies’ gifts to doctors and to continuing medical education programs have elicited new restrictive guidelines.”

“The public has become more suspicious of the motives of healthcare providers as their behavior has appeared increasingly selfish, an inversion of the traditional motive for healthcare. Individualism promotes cynicism about altruism and increasingly frank admissions of self-interest. More and more healthcare providers regard their work as little different from that in other careers. The traditional ethos of medicine, *primum non nocere* (first do no harm), is being

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www.rwhc.com/Awards/MonatoPrize.aspx

replaced by the ethos of the marketplace, *caveat emptor* (let the buyer beware).”

Other as Threat – “A hallmark of contemporary healthcare is the medical malpractice suit and the

defensive medicine practiced to protect against it. Patients enter relationships with providers with a consumer’s product-liability mentality. Providers are increasingly wary of their patients as potential litigants. Tests and procedures whose only justification is protection against potential lawsuits add millions to our healthcare costs annually. Lawyers on contingent-fee arrangements bring suits that healthcare providers frequently find wholly without merit, but insurers settle to avoid the costs of trials.”

“This litigious environment distorts clinical judgments and policy choices. Before asking what is best for a patient and right for a community, many providers ask what the law requires and whether they can be sued in the event of a bad outcome. Moral and political judgment is preempted by legal fears. The mission of healing and helping those in need is undermined by the perception of patients as threats.”

Unpooling Risk – “The clearest example of the triumph of libertarian individualism and consequent distortion of a sense of community in healthcare is contemporary health insurance. The social function of insurance is to pool risk, to spread the financial burden of sickness. At its inception, most health insurance was based on community rating, that is, on a single premium and benefit package for all. But most insurance is now sold on the basis of experience rating, that is, with premiums and benefit structures tied to group or individual experience with illness and health risk. Thus those who have been ill and those who are likely to be ill pay more for less coverage, if they can afford it at all.”

“This marketing strategy creates the uninsurable, the untouchables of healthcare financing. Excluding those with significant experience with illness and those at high risk of becoming ill is not only a conscious industry strategy, but also a response to a growing public demand. Americans appear to want risk-adjusted health insurance premiums. Our indi-

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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vidualistic sense of fairness entails that those who may cost more should pay more.”

“But experience rating undermines the social justification for health insurance by marginalizing those most in need of coverage. In essence, increasing risk segmentation in health insurance is a refusal by the wealthy and the well to share the financial burden of caring for the sick and the poor.”

Political Integration – “Risk segmentation in health insurance must be ended and the pooling of risks restored as the main ethical value of healthcare financing. No American should be uninsured. A community of shared risk between the wealthy and well and the poor and sick must be established.”

“Americans need a more complete conception of freedom, one that sees opportunities in relationships with others and not simply limitations. The handicapped, the sick, and the dying should be brought into the mainstream of life. We must reexamine the role of government, searching for ways to use it as a partner to help create a system that is both equitable to all and capable of containing costs. The experiment in the 1980s with the commercialization of healthcare has reached its ethical limit and should be reversed. A right to healthcare must be established and guaranteed in a system that retains its plural vitality, yet provides a basic level of care sufficiently comprehensive to address healthcare needs across the United States.”

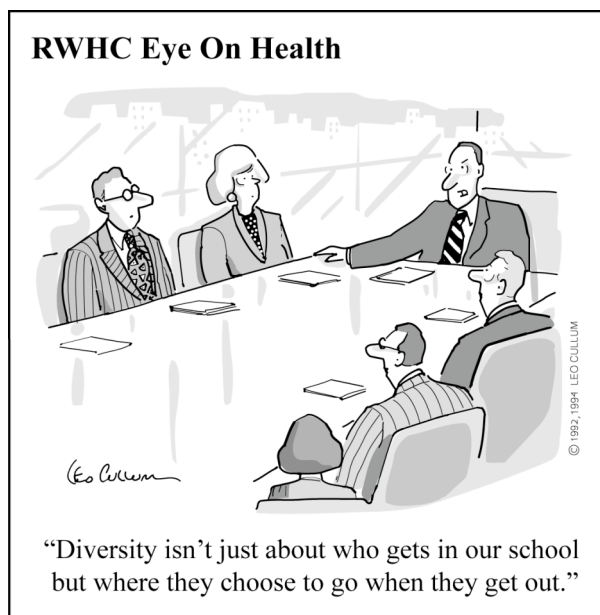
“Health should be regarded as something to be actively engaged in, not something to be bought as a commodity. Physicians should be freed to make clinical judgments in the best interests of the patients they serve, with a minimum of third-party interference. Administration must be simplified so that professionals can maintain their fiduciary relationships with their patients.”

“Renewal of our sense of community, while we preserve the important achievements of respect for individual persons, is the most important challenge at hand. It is a matter of striking a new sense of balance in our most fundamental values.”

Med Schools Get the Results They Select For

From “Family Medicine Practice in Rural Any-Country” by Cynda Ann Johnson, MD, MBA; Bruce E. Johnson, MD, in International Family Medicine Education, 1/08:

“Regardless of whether a country is developed or developing, the ‘rurality’ factor permeates physician distribution. Left to choice, most doctors would rather practice in cities and towns than in villages or countrysides.”



“From the beginnings of our careers as family physician and internist, we have been involved in the challenges of placing physicians in rural areas. In our respective roles in academic medicine, we have tried to address that challenge through development of programs to encourage graduating doctors to practice in areas of need. In both Kansas and Iowa, Dr. Cynda Ann Johnson helped to spearhead rural resident training tracks. While these tracks produce a greater percentage of graduates entering rural practice than tradi-

tional family medicine residencies, many of the programs have closed because of difficulty in attracting a pool of residents. At the undergraduate medical education level, Dr. Bruce Johnson has directed medical student courses, with a focus on rural/community experience to encourage consideration of rural practice.”

“Our first in-depth exploration of this issue in another country came during a sabbatical year in England in 1988. The National Health Service in England rather

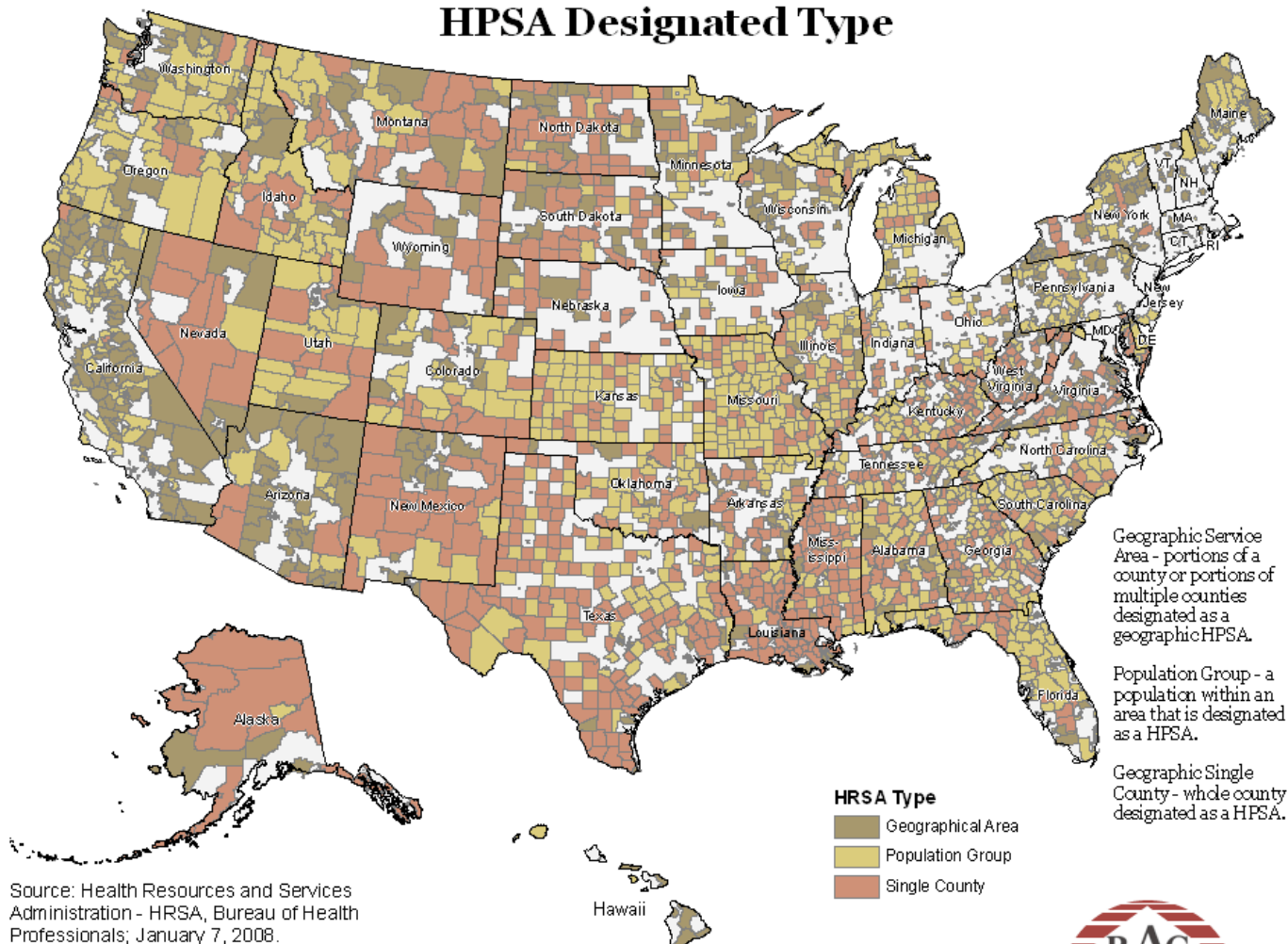
effectively controlled the distribution of doctors. The government designated the practice positions or ‘posts’ that were available. Even with this degree of control, and despite a relative excess of doctors seeking practice sites, rural posts would often go unfilled. Indeed, doctors would continue in a residency or ‘registrar’ position for years until a post became available in a location where they wished to practice. We interviewed one doctor who had been a registrar for 14 years, waiting for a location she considered desirable.”

“Over the years, we have seen this pattern repeated in many countries. In each there have been repeated attempts to persuade, entice, woo, or force doctors to locate in rural areas. No matter if the country is primarily rural, some areas are more rural than others and these more-rural areas have more difficulty attracting doctors.”

“Japan also has a problem enticing doctors to the relatively rural parts of the country and until recently, the training paradigm greatly emphasized specialties, effectively eliminating most graduates from even considering a rural setting. To remedy this problem, the government has recently required 2 years of generalist training for all graduating medical students, and family medicine residencies are increasing. It is still too early to know if this effort will provide a solution to rural recruitment. Thus, even countries that have changed training patterns and achieved increased numbers of generalist physicians still face the challenge of recruitment to rural settings.”

“By size alone, it stands to reason that China would have the greatest problem of any country in the world in locating doctors to rural areas. In 2002, Lexin Wang looked at the eventual practice location of doctors graduating from 10 rural and 12 metropolitan

Health Professional Shortage Areas (HPSA) - Primary Health HPSA Designated Type



Chinese medical schools. Ten of the 12 metropolitan schools did not produce a single rural physician! Last year, faculty from the medical school in Ningxa, a newer school in an isolated area of north central China, approached us at East Carolina University (ECU). They worry that their graduates will not meet the rural needs of the region and are hoping to find some solutions from the West. Here at ECU, we have a strong record of graduating students who choose rural practice. **We have shown our Chinese colleagues that the key for us is to select students for admission who are likely to locate in rural areas.** The strongest predictors include interest in primary care and growing up in a rural community. One quarter of our graduates practice in Eastern North Carolina, an almost entirely rural region, with additional graduates in other rural areas.”

“As our travels continued over the years, we became increasingly conscious of this worldwide pattern of rural doctor shortage and governments’ need to address this maldistribution. Many approaches have been tried. In some settings, careful selection of medical school applicants along with inducements to locate in rural sites seem to work. We need to work collaboratively with our international colleagues to find models that effectively address this global problem of physician maldistribution.”

Occasionally, a Good Idea from New York

From an editorial, “Doctors Where They’re Needed” in The New York Times, 1/15/08:

“Few things are more frightening than knowing you live too far away from the nearest doctor. Yet in many rural or poor urban areas there are far too few doctors to serve the community, and the problem is getting worse.”

“Because the federal government has done too little in recent years to encourage doctors to take these less-glamorous posts, New York and other states are looking for ways to fill the gaps in medical care. Unlike some areas, New York is not lacking in medical school graduates; there are new interns out there in droves. The problem is that after they graduate, not

enough of them decide to venture into the cold north upstate or the poorest urban neighborhoods.”

“New York’s governor, Eliot Spitzer, has announced plans to create a kind of Peace Corps for doctors called ‘Doctors Across New York.’ The idea is to help lure physicians into practicing in areas where a quarter of the state’s population is officially underserved.”

“To make that happen, Mr. Spitzer wants to provide up to \$150,000 in awards—for a five-year employment commitment—to help pay off medical school loans. Right now, the state offers a paltry \$10,000 in loan forgiveness per year for two years served in one of these areas, barely a down payment on medical school debt that now averages up to \$160,000.”

“This program might turn out to be little more than a stopgap as baby boomers age and need more care—while the nation’s supply of doctors fails to keep up. The last thing patients in these underserved areas need is even more competition for expert medical care.”

Medical Myths That Can Kill You

From “Medical Myths That Can Kill You—And the 101 Truths that will Save, Extend, and Improve Your Life” by Nancy L. Snyderman, M.D., Chief Medical Editor, NBC News. This book, written for the general public, comes out this May and can and should be ordered in advance from your favorite bookstore or web site:

Myth #1—Annual Checkups Are Obsolete

Myth #2—Vaccinations Are Just for Kids

Myth #3—Doctors Don’t Play Favorites

Myth #4—Only Old People Get Heart Disease & Stroke

Myth #5—We’re Losing the War on Cancer

Myth #6—Natural Means ‘Safe’

Myth #7—You Can Just Snap Out of Mental Illness

“There is a challenge you and I face: to stay healthy and live longer we need to understand and evaluate ‘medical myths’ and learn to act on the truths behind them. Dictionaries define myths as widely held but mistaken beliefs, misconceptions or misrepresenta-

tions of the truth, or exaggerated conceptions of people and institutions. Myths are like smokescreens.”

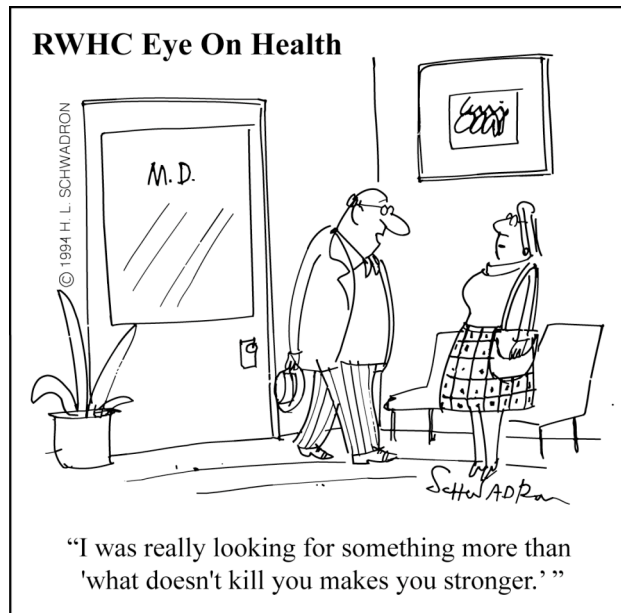
“They prevent us from focusing clearly on the real issues and options, and most of the time we are unaware of the degree to which they shape our thoughts and guide our actions. In *Medical Myths That Can Kill You—And the 101 Truths that Will Save, Extend and Improve Your Life*, I’ll help you figure out what is true, what isn’t, and how to punch holes in myths you’ve come to believe.”

“This book gives you the medical information you need to help you make informed decisions about how to:

- Get connected to the process of your own health care (yes, there is a process)—what tests, screenings, and vaccinations you need to stay healthy—and make health decisions that will benefit you most.
- Demand respect and appropriate treatment from a health-care system that isn’t always fair.
- Prevent and treat the three leading causes of death in men and women—heart disease, cancer, and stroke—through awareness, self-care, prevention, and treatment.
- Learn to reverse controllable risk factors and potentially add seven years of healthy living to your life.
- Discover how a healthy mind influences a healthy body, so that you can stay well, remain active, and get the most out of your life.”

“Understanding medical myths clears the way to the truth and helps you see what you need to do for yourself to live a healthier, happier, and more fulfilled life. Along the way, you’ll discover there are plenty of health issues over which you have a lot more control than you think. The more you know, the more prepared you are, and the better your underlying

RWHC Eye On Health



health—the better your chances of surviving *any* medical challenge thrown your way.”

“This book isn’t a big essay or opinion piece on medical myths—on every page, there’s advice and a plan of action to help you get the most out of the life you are living. It will help you treat your body as a loving friend, with enough information to help you change the habits that have plagued you up till now and correct any misinformation

that inadvertently may have kept you from living up to your full health potential.”

“However you choose to use the information in this book, my intention is that you use it as an encouraging and reassuring reminder of what’s important to our health—and what’s not. It is my hope that what I have to say brings renewed health and energy to your life, extends it, and possibly even saves it.”

Hospital Partners to Create Job Opportunities

Monthly, “Eye On Health” showcases a RWHC member story from the Wisconsin Hospital Associations’ annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month’s feature is from Fort HealthCare, Fort Atkinson, “Fort Memorial Hospital teams up with Opportunities, Inc.”:

“With the new 96,000 sq. ft. addition completed in December, ‘05 and departments being moved to newer and bigger areas, Fort Memorial Hospital saw a need for some additional assistance and Opportunities, Inc. stepped up to fill that need. Opportunities, Inc. was founded by a group of parents who wanted their developmentally disabled children to have a job after graduation. About a year and a half ago, Amy Christian, Customer Service Representative from

Opportunities, Inc., attended a monthly meeting of all hospital managers to explain how Opportunities, Inc. provides services to address employment needs of area businesses. Fort HealthCare's Environmental Services Manager approached Christian after the meeting to explore the potential for a collaborative relationship between the organizations."

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"He recognized that because of the creation of new, larger patient care units, patient service associates (PSAs) who deliver food and otherwise help to meet routine patient needs, would have increased space to cover. Opportunities, Inc. appeared to be able to help meet that need."

"Having mentally and physically challenged individuals from Opportunities, Inc. gain work experience and test their abilities at Fort Memorial Hospital began on Dec. 12 in Obstetrics (OB) and on Dec. 13 in Medical/Surgical/Pediatrics (MSP). The workers help maintain supplies on the units and stock nurse-server outside each patient room."

"Since Opportunities, Inc. and Fort Memorial Hospital teamed up, the result has been positive. The response from the PSAs and nursing staff has been very positive. Pam Kuehl, RN, Manager of MSP, loves the program. 'The staff from Opportunities, Inc. is so nice. They are providing a wonderful service. They help the nurses provide care to the patients by having clean linens right outside the door for nurses to use. This is a wonderful relationship between Fort Hospital and Opportunities.'"

"Every new worker has a six-week employment experience to 'try out' the job and for Fort Memorial Hospital managers to observe the person's skills. Job placements are funded through the Wisconsin Division of Vocational Rehabilitation (DVR), an agency charged with assisting persons with disabilities succeed in the work force. The DVR contracts through agencies like Opportunities, Inc. to provide direct services."

"For over 40 years, Opportunities Inc. has provided program and employment in the community and currently serves over 2,000 persons on an annual basis

with disabilities and barriers to employment. Their mission is to provide services to individuals to maximize their success and enhance their abilities to be independent,

contributing members of the community. Nearly 80 percent of their work placements are in community settings like Fort Memorial Hospital."

Were They Really the Good Old Days?

From Terry Brenny, President/CEO, Stoughton Hospital, Stoughton, Wisconsin, in a year-end message to hospital employees:

"The new year prompts one to reflect on the future, but can also trigger a glimpse in retrospection."

"At the risk of dating myself, I recall the 70s in healthcare as a decade thought by health administrators to be a relatively stable era of third party cost reimbursements (generally favorable), mild government regulation, prevalent commercial health insurance with considerable freedom of choice for enrollees, hospitals, physicians, high hospital inpatient occupancies, generously long length of stays, many independent hospitals in the nation."

"Patients were generally considered stable commodities that were dependent on, and expected to conform to our traditional systems, protocols, and policies. Remember limited, restricted visiting hours, multi-occupant patient rooms, schedules based on tradition and convenience of the organization, generally bland institutional food and diets? Were these the good old days?"

"Since then, our industry has experienced increased government regulation, prospective reimbursements (DRGs etc.), hospital closures, consolidations, multi-hospital integration and system development nationwide, advent and penetration of managed care (HMOs, PPOs that restrict patient and provider choice and constrain reimbursement to providers), increased emphasis on outpatient and non-institutional modalities among other forces, trends."

“The healthcare industry clamored for, and is now experiencing growing competition among providers—market forces that some people argue are good and some bad. Nationally and regionally, systems strive to expand and lock in geographical markets with health plans, incentives, penalties, restrictive policies and practitioner panels that channel patients and customers to contracted system hospitals and medical clinics.”



“There is a dramatic push to develop advanced medical and information technologies and medical breakthroughs, which have contributed to the escalating cost of healthcare, further exacerbated by swelling, aging populations that expect and demand the latest, best, and most convenient. The growing masses of the uninsured and underinsured further add pressure and stress to the health care system and associated costs. The high cost of health care has been identified as one of the most pressing public policy issues in the country with 47 million Americans without insurance.”

“Evolving over the years has been the development of consumer driven healthcare. Better educated and in-

formed consumers expect more transparency, accountability for resource deployment, quality and safe outcomes at a reasonable cost...taken together these factors affect perceived value. In addition to the traditional forces exerted by government

and other regulatory and accreditation agencies, businesses, alliances, purchasing cooperatives have assumed greater involvement, monitoring and control for the purported benefit of their enrollees and members.”

“Perhaps the most recent health system trend has been the focus and commitment to Mission, community based healthcare, benefit, value, customer orientation. From increasingly popular customer service programs which many hospitals are now implementing ... to the complete redesign of healthcare facilities and campuses with the customer as the starting and end point are healthy and perhaps overdue trends. The patient (and supporting family) have been rightfully engaged and served as health care’s primary customers.”

“We have come a long ways in our ongoing journey to achieve and sustain excellence and customer satisfaction. That is what Mission is all about.”

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