

Review & Commentary on Health Policy Issues for a Rural Perspective – February 1st, 2005

What Does America Want from Its Congress?

From the survey: “Health Care Agenda for the New Congress” by the Kaiser Family Foundation, 1/05 at www.kff.org/kaiserpolls/pomr011105pkg.cfm:

“The public favors reducing jury awards in malpractice lawsuits and allowing drugs to be imported from Canada, but ranks them relatively low on a list of 12 health care priorities for President Bush and Congress to address this year, according to a new post-election survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health.”

“Just over a quarter (26%) of the public cite reducing malpractice jury awards as a top priority for the President and Congress, ranking 11th on the list, just ahead of increasing federal funding for stem cell research (21%). Just under a third (31%) cite allowing drugs to be imported from Canada as a top priority, ranking eighth on the priority list.”

“At the top of the list, almost two thirds (63%) of U.S. adults cite lowering the costs of health care and health insurance as a top priority for the President and Congress, followed by making Medicare more fiscally sound for the

“Wisconsin’s Health Care Safety Net: What is Your Role?”

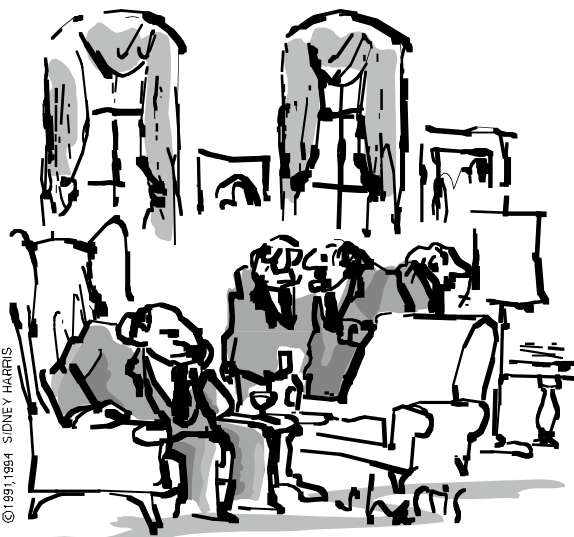
The Wisconsin Primary Health Care Association invites you to a free, one-day conference in Madison on Thursday, February, 17th. Local, regional, and national speakers will present on various issues related to the health care safety net including the future of Medicaid. A brochure and online registration is available on the web at www.wphca.org/ or contact Abby Watermolen at awatermolen@wphca.org.

future (58%) and increasing the number of Americans with health insurance (57%).”

“Overall, U.S. adults rank health care issues third when asked to name the single most important priority for the President and Congress to address. Fewer Americans cite health care issues (10%) than the war in Iraq (27%) or economic issues (17%). Terrorism/national security (10%) tied with health care as the third-most cited issue. The survey is based on a nationally representative sample of 1,396 adults and was conducted from Nov. 4-28, 2004.”

“**Healthcare costs**—Lowering the cost of health care and insurance was named as a top priority for the President and Congress by 63% of the public, and by an equal share of Republicans (61%) and Democrats (61%). Asked about the causes of rising health care costs, 29% of Americans say that high profits made by drug and insurance companies are the most important factor, while 22% say the number of malpractice lawsuits and 15% say the amount of greed and

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“He is still trying to reconcile 'love thy neighbor as thyself' with ignoring 40 million people without health insurance.”

“Gentlemen, I take it that we are all in complete agreement on the decision here. Then I propose we postpone further discussion...to give ourselves time to develop disagreements and perhaps gain some understanding of what the decision is all about.” Alfred Sloan
RWHC Eye On Health, 1/17/05

waste that occurs in the health care system. In comparison, 7% cite the costs of medical technology and drugs, a factor many health care experts cite as a major driver of higher health care costs.”

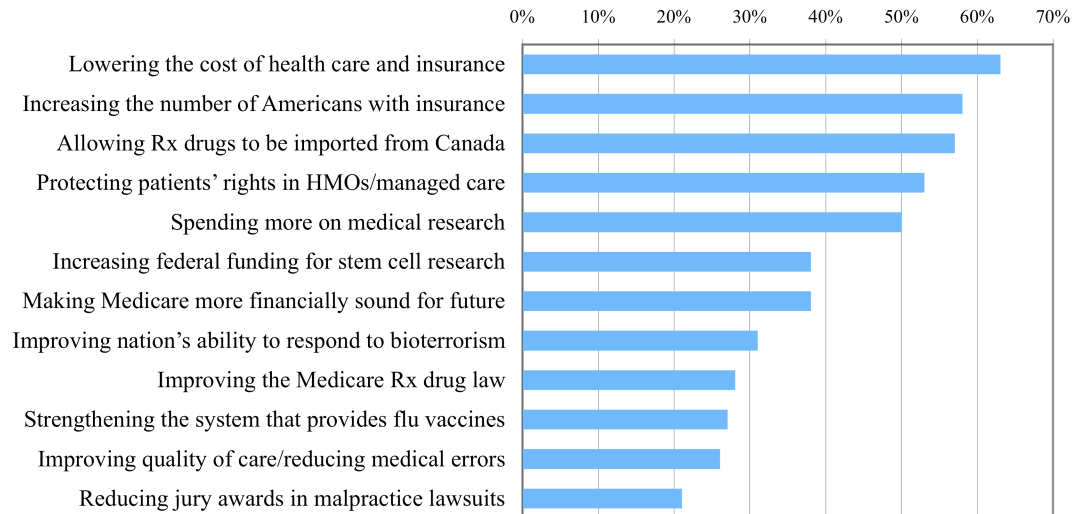
“Expanding health coverage for the uninsured—The public places a relatively high priority on increasing the number of Americans with health insurance. More than half (57%)

cite the issue as a top health care priority for the President and Congress—making it the third most-cited health-care priority behind lowering health-care costs and making Medicare more financially sound.”

“However, the public does not agree on a single best approach and is relatively evenly divided on a number of potential policy approaches. When asked to choose their most preferred option to increase the number of Americans with health insurance, 23% say offering businesses tax deductions or other financial assistance to help them provide health insurance to their employees, while 17% say offering tax deductions or other financial assistance to help individuals pay for private insurance and 17% say expanding state government programs such as Medicaid. Smaller shares (between 12% and 15%) say they most prefer other options, such as a national government health plan, expanding Medicare to cover people under age 65, and requiring businesses to offer health insurance for their employees.”

“Americans are also divided on whether they are willing to pay more, either in taxes or in higher health insurance premiums, to expand coverage to the uninsured—with 51% saying they would not be willing to pay more, and 45% saying they would be willing to pay more. Another 4% were unsure. Democrats (59%) are significantly more likely to be willing to pay more than Republicans (36%).”

Percent saying each of the following should be a top priority for the President and Congress this year ...



Data: Kaiser Family Foundation/Harvard School of Public Health Survey, 1/05
Chart: RWHC, 1/05

Getting Kids Through School is Health Care

From “Good Education Policy is Good Health Policy OR Why are Better Educated People Healthier? by David Kindig, MD at the University of Wisconsin in the *Wisconsin State Journal*, 12/19/04:

“Your recent story on the 2004 release of county health rankings by the Wisconsin Public Health and Health Policy Institute had the headline “Go to College and You Might Live Longer”, and displayed data that in Dane County persons with less than high school education are three more times likely to die before age 65 than those with more than a high school education. How could a social factor like education be so important in producing longer and healthier lives?”

“We all understand how important our medical care system is to our health. From polio vaccines to insulin to life saving and enhancing surgery, most medical care makes us healthier. It is also well known that other factors like our genetic makeup, the quality of the environment, and our health behavior choices like smoking and diet influence our health for better or worse.”

“What is less well appreciated is that factors like education, occupation, and income have also been shown to have a powerful, independent impact on health. While teasing apart the effects of these factors is challenging for researchers, the evidence is convincing that level of education is probably as important as medical care and other factors in improving health. A large body of evidence supports this claim, including the fact that people in nations, states and counties with higher education rates are healthier. Persons with more education have fewer disabilities, better physical functioning, and longer lives. One of the most precise studies, which controlled for many other possible explanations, showed a 1 to 3% reduction in mortality rates for each year of additional schooling.”

“How could education have an impact on biological processes that produce death or disability? There are probably two pathways. The first operates directly, through better understanding about health and disease processes including prevention. It has also been suggested that more education may directly enhance the ability to make difficult short term decisions (e.g., stop smoking; eat better; routinely exercise) which affect health later in life. A second pathway is more indirect, as persons with more education have better occupations and higher incomes which in turn result in better access to health care and often less stress in many aspects of life.”

“While we need more research and information on relationships between health and education, we know enough now to act. Both the direct and indirect mechanisms take a long time to have their effect. In Wisconsin the range in high school graduation rates across counties is from 75% to 92%; across the whole country the variation is even much greater. Similar variation certainly exists regarding the quality of education as well. Increasing the amount and quality of education would not only provide the well-known benefits such as occupation and income and the ability to function in a democracy, but would also improve the length and quality of people’s lives.”

“Education and health policy should be considered together, not separately. The cost of medical care has grown from 6% to 14% of our Gross Domestic Product since 1960. In that same time period, education expenditure has remained between 6 and 7%. As a nation we just added \$400 Billion for Medicare drug cover-

RWHC Eye On Health



"I think I got a good malpractice case for my high school dropping me before graduation."

age. We must make similar levels of investment in State and local budgets to improve the amount and quality of education our school children receive and for early childhood development programs that increase readiness to learn. While the broad economic and social benefits alone can justify such investments, increased expenditures on education are also one of the best investments in health we can make.”

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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Rural Health Is Economic Engine

From “Health Care in Rural America: A Potentially Powerful Economic Engine” in the *National Conference of State Legislatures State Health Notes*, 10/04:

“The list of challenges facing rural America is daunting. Studies show that rural populations tend to be older, poorer, are more likely to be uninsured and have lower levels of education than their urban and suburban counterparts—all of which can contribute to a lower health status and a greater need for health-care services.”

“But there’s another reason that health care is crucial to rural areas: jobs. Managers who are looking for new locations often look for access to high-quality health care. For these and other reasons, one of the best industries that rural areas can attract is health care itself.”

“ ‘There are three major roles for health care in rural economic development: as a contributor to the local economy; as an economic base industry attracting external dollars; and as a factor to recruit businesses, workers and retirees to the community,’ said Eric Scorsone, assistant professor at the Department of Agricultural Economics, University of Kentucky. Providing health-care services is labor intensive. At last count, a national average of 10 to 15 percent of rural workers were directly employed by the health-care industry, Scorsone said.”

“ ‘Hospitals are often the second or third largest employer in rural areas,’ said Brad Gibbens, associate director of the University of North Dakota’s Center for Rural Health. A single rural physician can generate more than five jobs and over \$232,000 in additional income each year in a rural community. And there’s a multiplier effect—each health-care dollar rolls over in a rural community approximately 1.5 times. If a rural hospital employs 80 people directly, another 40 jobs are created in the community as the physicians, nurses, pharmacists and aides build houses, eat at restaurants, purchase groceries and enroll their children in the local child-care centers.”

“Also contributing to local prosperity, hospitals and other health-care providers ‘sell’ services to third-party payers like private health insurance, Medicare and Medicaid. These external sources of income would not filter into the community without the health service provider.”

“Not an Easy Task—But attracting or sustaining a hospital, or even a physician’s office or clinic, can be a daunting challenge. Rural areas have 20 percent of the U.S. population and less than 9 percent of practicing physicians. Why? Rural physician practices are often solo, with nearly endless ‘oncall’ shifts, little support from other health professionals and reduced earnings compared to most urban practices.”

“Rural Americans are more likely to be uninsured than urban dwellers, largely because they are less likely to have employer sponsored coverage, according to a March 2004 policy brief from the National Rural Health Association (NRHA). Rural Americans have an uninsured rate that is 6 percent higher than that of urban Americans because their employer-sponsored coverage rate is 11.5 percent lower than their urban counterparts’, the NRHA said.”

“ ‘With the aging rural population and the disproportionate share of low-income folks in our rural areas, providers depend on Medicare and Medicaid reimbursements, but it is hard to earn a living that way,’ said Rep. Lynn Kessler, House majority leader in Washington. Historically, Medicare has paid rural providers less than it pays their urban counterparts—for the same exact service. And Medicaid rates tend to be lowest of all. Gibbens agreed that this is a problem but pointed out that there is movement by the federal government to “equalize” the payments—at least for Medicare. ‘In time, it shouldn’t matter if you are providing the service in rural America or urban America, the Medicare payment will be the same,’ he said.”

“Grow Your Own—‘Recruitment and retention of health care professionals is a major issue for our rural communities,’ said North Dakota Rep. Ken Svedgen. But states are taking steps to fill in the gaps. In an effort to get health providers out to its rural areas, North Dakota, like many other states, passed laws creating loan repayment programs for physicians, nurse practitioners and dentists.”

“Svedgen is a big fan of the ‘grow-your-own’ concept because students who are trained in North Dakota are more likely to stay. ‘The focus of the medical school here is to train family practice physicians largely because that is what the rural communities need,’ he said.”

“ ‘Idaho did a great deal to assist rural communities in recruiting health professionals,’ said Idaho Rep. Sharon Block. ‘We tried to help providers economically by passing tort reform legislation to help lower liability insurance premiums as well as providing for loan repayment.’ Because Idaho does not have a medical school, the legislature also has an agreement with two out-of-state schools in an effort to import practitioners.”

“Block would like to see smaller communities use mid-level practitioners, such as physician assistants and nurse practitioners, to extend the services of the rare rural doctor. As a matter of fact, North Dakota is doing just that. ‘We have expanded the scope-of-practice for nurse practitioners, which could be an important component to the access issue in rural areas,’ said Svedgen.”

No Out-Shopping—Another difficulty rural areas face is ‘outshopping’—when residents bypass local providers to purchase health-care services in urban areas. This not only deprives the local area of needed dollars, but may contribute to that area’s eventual loss of its provider. According to Tess Ford, director of the Center for Rural Health and Social Service Development at Southern Illinois University, ‘Bigger is better in many health consumers’ eyes.’ ‘Only about 30 percent of the people in my state’s rural communities use their local hospitals,’ added North Dakota’s Svedgen. The remainder travel to the more urban areas for services.”

“The same is true in Washington Rep. Lynn Kessler’s district. ‘Health-care dollars escape from my counties all of the time,’ she said. ‘Local communities need to let people know about the health-care services available.’ To address those escaping dollars, communities and providers are working together to market their health-care services and improve their quality. ‘When communities contribute to the design of local health-care services, they are more apt to spend their healthcare dollars locally,’ Ford said.”

“Marketing high-quality health services and creating a link between business groups, the community and the health-care sector are important steps to keeping health-care dollars at home and improving the quality of local health care, agreed Scorsone. But he cited two major hurdles: that local economic development committees rarely communicate with health-service providers, and, again, that recruiting and retaining high quality health staff in rural areas remains an ongoing and complicated issue.”

“ ‘When we go into the local communities to help, we almost always recommend a task force led by the Chamber of Commerce, which includes the health sector,’ Scorsone said.”

“A Case in Point—Grays Harbor County is located on the Olympic Peninsula in Washington about 75 miles from Seattle. This rural county—there are about 35 people per square mile—offers rolling tree-covered hills and beautiful ocean beaches, giving way to rugged mountains in the northernmost area. In the middle of the major population base, on the top of a hill overlooking the bay, lies Grays Harbor Community Hospital. County residents look to the hospital not only for high-quality healthcare services but for jobs and a boost to the local economy.”

“ ‘The hospital employs about 600 people, which makes it the third largest employer in the county,’ said Michael Tracy, executive director of the Grays Harbor Economic Development Council. In Grays Harbor, ‘the hospital and the local economic development council have a very close relationship.’ In fact, the president of the Council works for the hospital.”

“The people in the community also support the hospital. ‘This community shows its heart when it comes to assisting the hospital,’ said Kim Woodford, director of guest relations and administrator of volunteer services at the hospital. Not only does the community do a ‘fantastic job’ of volunteering their time but they also support the fundraisers—book, art and jewelry sales to name a few.”

“ ‘Over the years, the volunteer auxiliary purchased many needed items for the hospital, with the most recent being an ultrasound machine that helps place IV equipment and dental x-ray equipment for a new pediatric dentist,’ Woodford said. In another example

of a town pulling together to bolster its health-care providers, a community organization joined with the local hospital to market new health-care services—chemotherapy and oncology—to area residents.”

“ ‘These were services that the locals were traveling great distances to receive on a regular basis,’ Kessler said. The result was satisfied customers who, through word of mouth and letters to the editor, helped to increase patronage for the local health-care providers. ‘Word of mouth is a tremendous force’ in rural areas, Kessler said.”

“A variety of federal and state programs exist to help maintain and increase the healthcare workforce in rural areas. The National Health Service Corps provides scholarships and loan repayment to physicians and other health professionals who agree to serve in rural and urban underserved areas. In addition, they administer the State Loan Repayment program, which provides funds to the states for their own loan repayment programs.”

“Sometimes it is the local government or hospital that provides incentive for recruiting providers. Kessler noted that one rural hospital in her district subsidizes the wages of its physicians in an effort to recruit them. The hospital guarantees them a certain level of income and makes up any gap between what they take in and the guaranteed level.”

“ ‘Health-care providers—doctors, nurses, pharmacists—look at the same things in a community that businesses do when making a decision to relocate,’ Tracy said. The economic development council helps build the infrastructure that aids the hospital in recruitment of workers. And the hospital, with its high-quality services, makes attraction of other industries possible. ‘The assistance goes both ways,’ Tracy said.”

Leapfrog Shifts to Leverage Health Plans

From “Has the Leapfrog Group Had an Impact On the Health Care Market?” by Robert S. Galvin, Suzanne Delbanco, Arnold Milstein and Greg Belden in *Health Affairs*, January/February 2005:

“A number of large employers and public purchasers founded the Leapfrog Group in 2000 in an attempt to consolidate the purchaser voice and engage consumers and clinicians in improving health care quality. Drawing on evidence-based medicine, Leapfrog publicly releases information about the extent to which (“non-rural”) hospitals are adopting three safety ‘leaps’ with the theoretical capacity to prevent thousands of deaths. Although the group has grown rapidly and achieved national recognition, employer-based initiatives historically have struggled to create changes in health care.”

Challenges Ahead

Too Few Hospitals Participating. “Balancing Leapfrog Group’s favorable effects is the small number of hospitals that have implemented the leaps and the lack of documentation of resulting clinical and financial improvements. A paper from the Center for Studying Health System Change indicated that in many communities, although hospitals were aware of the Leapfrog Group, little change in their operating decisions had resulted. In addition, surveys have indicated that despite a small increase in the number of consumers using performance data to guide their health care selections, the majority have not changed the way they make health care decisions.”

Reasons for Slow Diffusion. “Why, despite its large membership, clear goals, and national recognition, has the Leapfrog Group not had a larger impact? There are several possible explanations.”

“Expectations of rapid change. In the attempt to make bold progress, Leapfrog developed standards that could dramatically reduce the number of preventable hospital deaths. These leaps are difficult to attain, require capital investment as well as culture change, and have been controversial with hospitals and physicians. The Leapfrog Group has tried to balance its insistence on ‘leaps’ with refinements based on recommendations by providers and has modified its measures in coordination with specialty societies and measurement experts. However, changes in complex systems do not occur rapidly. Adopting CPOE, for example, demands major change in physicians’ behavior. It is known from the literature on diffusion of innovations that changes of this complexity are better measured in decades than in years.”

“Absence of business case. Although performance transparency creates some motivation for change, providers have insisted on a robust business case for quality both to fund implementation of the leaps and to reward them for improvements. The Empire Blue Cross Blue Shield project is an example of the difficulty in developing a business case for quality. Although the initiative took considerable resources to develop, the rewards paid out to the participating hospitals that met the Leapfrog standards were on the order of a couple hundred thousand dollars a year. This prompted one of the hospital CEOs to say that while his institution appreciated the reward, the amount of money fell far short of what was needed to influence decisions about capital investment. Actuarial analyses suggest the need to expand beyond the initial leaps so that performance is based on measures that apply to greater numbers of hospital admissions and pertain to the areas of care on which employers spend the most.”

“Reluctance of purchasers. Ultimately, Leapfrog’s success may be as limited by the reluctance of its purchaser-members as by that of providers. The amount of rewards paid, or patient volume redirected, is a function of the number of participating purchasers and the vigor of their participation. It has been surprisingly difficult to get purchasers’ attention. Even the most progressive purchasers are reluctant to change their purchasing behavior sufficiently to send clear market signals about quality to providers. Employers’ hesitation to restrict employees’ choice of providers makes it hard to convince providers that high quality will increase their market share.”

“Why is it so difficult to engage employers? First, employers are tremendously diverse. Among large employers, the purchasing is generally done by benefits professionals, a majority of whom were trained in retirement benefits and feel that they lack the exper-

tise to deal with the complexities of health care. Organizationally, they work in the human resource department, whose goals within the organization generally do not include having the operating skills necessary to effect change in the health care system. The majority of these large employers outsource their health care management to consultants, who have little financial interest in cooperating with competitors. With respect to rewarding performance, the challenge is compounded by difficulty in demonstrating the business case for paying more to any provider in an era when health care costs are increasing rapidly, even when these increases are attributable in part to poor quality. This is especially true when em-

ployers face pressure to make quarterly numbers, which makes long-term investment in quality improvement especially challenging. In the absence of widely available off-the-shelf products from health plans, major change is unlikely.”

Leapfrog’s Response.

“The Leapfrog Group is addressing the lack of purchaser engagement in two ways: (1) by returning to employers’ focus on health plans as the agent to effect change, and (2) by expanding their focus to broader measures of quality and efficiency. This represents an important shift from Leapfrog’s original strategy,

in which plans’ role was secondary and the focus was solely on hospital safety. A small number of large employers can have a great impact on health plan activity, and because of the consolidation in the health insurance market, these plans have the capacity to deliver sizable rewards for quality. Leapfrog will be encouraging employers to look to health plans to be their supply chain managers, helping drive increased value from the providers in their networks. The United Health Group has licensed the Bridges to Excellence program for use in multiple markets. A physician-reward program, spawned in part by Leapfrog California members, will pay more than \$100 million from six health

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plans this year. Leapfrog is preparing to launch a national hospital reward program focusing on five conditions that present a major opportunity for increased quality and efficiency in the commercial population: coronary artery bypass graft, percutaneous coronary intervention, acute myocardial infarction, community-acquired pneumonia, and deliveries/neonatal care. Delivered through participating health plans, this initiative is essentially a commercial version of the CMS-Premier P4P project, with the important exception that measures of efficiency are included in the criteria for rewards. More efficient care is less costly care, which helps develop for purchasers the business case for quality. Leapfrog members will be encouraged to ask their health plans to use the reward program or an alternative program with similar features as a means to fulfill their commitment to Leapfrog's purchasing principles."

"The impact of the Leapfrog Group is difficult to assess. Many of the actions that the group set out to catalyze, including the public release of performance measurement, use of information systems in clinical care, and reimbursement reforms to reward quality, have increased in prevalence. However, the number of

hospitals that have adopted the three 'leaps' remains small. The length of time it takes for major changes to occur and the inability of the group to generate a substantial business case for quality have limited its impact. Now the group's biggest challenge is the choice of motivating employers to increase their commitment to value-based purchasing or adopting a strategy that addresses this shortcoming. Leapfrog's new focus on health plans as the leveraging agent, as well as on the expansion of measures to include efficiency, is a promising strategy, but it is far too early to judge success. Leapfrog is a direct actor, but its most important impact has been as a powerful market catalyst. A unified large-employer sector would accelerate improvements in quality and efficiency, but whether the employer community can change its historical inability to act uniformly, or develop an alternate strategy to consolidate purchaser activity, remains to be seen."

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