

Review & Commentary on Health Policy Issues for a Rural Perspective – May 1<sup>st</sup>, 2006

## Physicians Tomorrow Requires Action Now

From “The Collapse of Primary Care” by Roger Rosenblatt, MD in *The Seattle Times*, 3/29/06:

“Health care in the United States is like a house riddled with termites. On the outside, everything looks fine: Gleaming hospital towers punctuate the skyline; MRI machines produce stunning images; and surgeons use robots to work miracles. But underneath the surface, the foundation is starting to sag: Tens of millions of people have no health insurance, emergency rooms are overwhelmed by patients who don’t have regular physicians, and the cost of medical care is rising into the stratosphere.”

“One of the reasons for the rot at the core is the impending collapse of primary care, the family doctors and other health-care professionals who are the foundation of the health-care system. Just as your house cannot stand without its supporting beams, neither can the health-care system function without doctors and other clinicians who are experts in primary care. They work to prevent illness before it occurs; manage people with complex chronic diseases; care for pregnant women and their babies; and attend to the men-

tal-health and substance-abuse problems that produce so much illness and social disruption.”

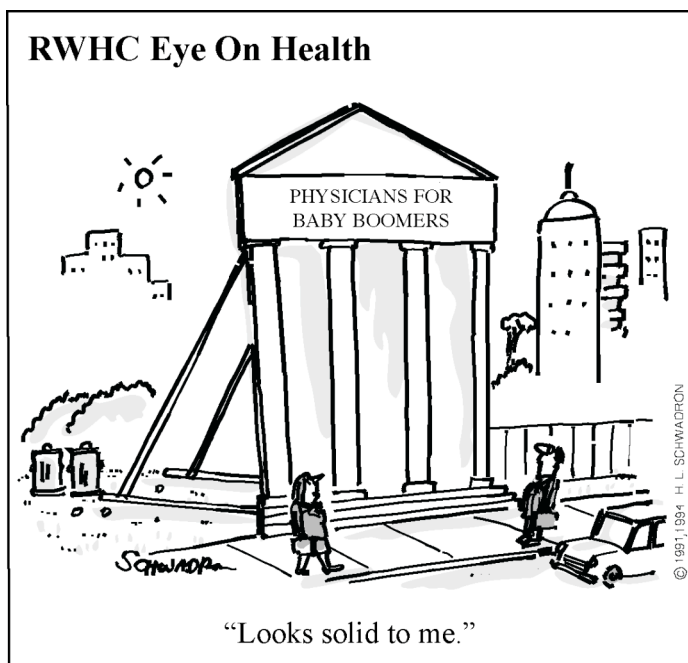
“Why is the primary-health-care system unraveling? The main reason is that new physicians are not choosing to pursue careers as family physicians and general internists, the two physician groups that provide pri-

mary care for adults. The number of medical students entering family medicine residencies—the graduate training programs that take medical students and turn them into licensed physicians—has declined 52% in seven years.”

“The reasons for this seismic shift in medical student career choice are not hard to find: Reimbursement rates for primary care have declined, student-loan debts have skyrocketed, and the complexity of caring for an aging population

has become more and more challenging. The situation has been made worse by the federal government’s decision to drastically cut funding for training family physicians (a program called Title VII) at the same time the need for these physicians has increased.”

“Other disciplines such as obstetrics, psychiatry and dentistry also have high rates of unfilled positions, but the largest aggregate need is for family physicians. The situation can only get worse, as those currently working retire and fewer and fewer new graduates are available to replace them.”



“The shortage of primary-care physicians in community health centers is an early sign of the structural weakness at the core of America’s health-care system, and will ultimately affect everyone. Research has shown that regions with more primary-care physicians have better health outcomes at lower cost. An adequate supply of primary-care physicians is vital to our society’s health and well-being.”

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## TeleHealth—Making Barriers Matter Less

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From “Using Telehealth to Reduce Disparities and Improve Care in Rural Communities” by Sarah Klein in The Commonwealth Fund Newsletter, *Quality Matters*, 3/06:

“Although rural health innovators have demonstrated that telehealth can improve care delivery, obstacles still stand in the way of its widespread adoption.”

“ ‘The biggest challenge is not patient acceptance, but provider acceptance,’ says Pam Whitten, Ph.D., at Purdue University who has established and researched telemedicine programs for more than a decade. ‘Quite candidly, I think this has more to do with [providers] being overburdened.’ They need to have ongoing support, as well as the proper infrastructure, to implement and maintain these programs at both the originating and remote sites, she says.”

The **Rural Wisconsin Health Cooperative (RWHC)** was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of 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.

*Eye On Health* Editor:

Tim Size, RWHC

880 Independence Lane, PO Box 490

Sauk City, WI 53583

<mailto:office@rwhc.com>

<http://www.rwhc.com>

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“Telehealth’s high approval ratings from rural patients, as well as such patients’ demonstrated need for specialty services, has led some private insurers, Medicaid programs, and Medicare to reimburse for selected telehealth services but ‘there have been [coverage] restrictions based on the setting and the type of interaction,’ that have led some doctors to question whether patients in a given area would be covered, says Laura Schopp, Ph.D., an associate professor at the University of Missouri in Columbia. Medicare, for instance, covers telemedicine in areas designated as rural health professional shortage areas—a definition based on a measure of primary care service, not specialty care. Medicaid coverage, for the poor and elderly, is determined by individual states, which use different standards for determining coverage. Though private insurers tend to do better than both government programs, the lack of consistency overall is troubling for providers.”

“In some respects, licensing has not caught up to technology. Providers who need to cross state lines to cover a rural area in a neighboring state rarely can do so. Cross-state practice would help further the technology’s reach. ‘There are about a dozen states that have relaxed the rules’ for telehealth, but the majority have not, says Peter M. Yellowlees, M.D., a professor at the University of California at Davis.”

**Lack of Infrastructure**—“A lack of local infrastructure also is an issue, as successful implementation requires additional resources and staff. Individual states have taken on the job of ensuring broadband networks and, as a result, there is a lack of uniformity. Arizona and Florida, for example, have made great strides, while other states have done virtually nothing, says Yellowlees, a coauthor of ‘Rural Health in the Digital Age: The Role of Information and Telecommunications Technologies in the Future of Rural Health,’ which was adapted for use in a 2004 Institute of Medicine (IOM) report on the future of rural health care.”

“In that report, the IOM recommends that Congress expand efforts by federal agencies to extend broadband networks into rural communities. As mentioned above, many rural communities don’t have broadband networks. But even those communities that have the necessary infrastructure face additional barriers: the costs associated with the use of tele-

communications lines as well as regulatory and payment environments that limit the use of information and communications technology.”

“The IOM’s Committee on the Future of Rural Health Care, which wrote the report, also recommended that the Office of the National Coordinator for Health Information provide leadership in evaluating the regulatory barriers to telemedicine. Once these issues are addressed, the IOM committee believes this technology ‘has enormous potential to enhance health and health care over the coming decade.’ ”

**Mental Health: A Telemedicine Model**—“Despite the challenges, digital technology can play a key role in breaking down access and quality barriers. Mental health has proven to be a good model for telemedicine in rural areas. The need for mental health services is particularly acute in remote and dispersed communities, and telemedicine offers unique advantages in filling that need.”

“Telemedicine programs in Maine, Kentucky, and other states are making substantial progress in delivering mental health services to remote locations, most of which lack even the most basic mental health services. Residents are forced to go without access or travel hundreds of miles for intermittent care, sometimes with devastating consequences:

- Suicide rates in rural areas are three times as high as in urban areas, according to the Centers for Disease Control and Prevention. Women in rural communities are particularly vulnerable. One study found 41 percent of women in central Virginia reported symptoms of depression compared with 13 to 20 percent of their urban counterparts.
- Substance abuse rates also are high among adults and adolescents in rural areas. Research by the Center on Addiction and Substance Abuse, for example, suggests that eighth-graders in rural communities are 83 percent more likely to use crack cocaine and 104 percent more likely to use amphetamines, including methamphetamines, than their peers in large metropolitan areas.”

**Broadband Breaks Barriers**—“Not only do broadband communication lines give small-town

### **Webcast: Understanding Tax-Exempt Financing**

A one-hour audio/visual and PowerPoint presentation by John Whiting, a Partner in the Madison office of Quarles & Brady LLP, is available online, “taped” at the recent annual Wisconsin Health and Educational Facilities Authority (WHEFA) workshop. It is designed for those who have never done a tax-exempt financing or have not done so for a long time.

John has extensive experience in tax-exempt health care and education financings, having provided bond counsel and general counsel services to WHEFA for 25 years. Topics covered in the one-hour presentation include legal aspects, terminology, financing team and financing structure issues.

Go to <http://www.rwhc.com> and click on “What’s New” or go to WHEFA’s website at <http://whefa.com> and click on “Workshop.” The presentation was recorded by RWHC with its new **Mediasite technology, available for other uses from RWHC to both its Members and strategic partners—for information, call Darrell Statz at 608-643-2343.**

residents access to psychiatrists and psychologists in urban communities, but they also enable them to preserve their privacy and save the expense of long-distance travel to hospitals.”

“Maine Telemedicine Services links roughly 300 provider sites with specialists at area hospitals. Patients visiting primary care physicians use a videoconferencing system to talk to a psychiatrist in another town. The psychiatrist then makes a treatment recommendation to the referring physician. Other patients have no way of knowing the nature of the consult, which preserves privacy.”

**Does Telemedicine Affect Quality?**—“Despite its benefits, telemedicine is not a panacea for mental health access problems, experts point out. Some psychiatric conditions, including paranoia and suicidal behavior, do not lend themselves to treatment via videoconferencing, Schopp says.”

“Also, many clinicians fear it will disrupt intimacy between doctors and patients. But that concern may be one-sided. Patients appear willing ‘to swap some of the intimacy for the convenience,’ Schopp says.”

“Though more outcomes data are needed, when it comes to patients’ perception of quality, ‘early findings suggest there is no difference between the two

types of consults,’ says John Scanlan, M.D., behavioral health medical director of Blue Cross and Blue Shield of Minnesota. ‘Quality is providing treatment when [patients] need it.’ ”

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## America Awash in Excess Certitude

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From “The Oddness of Everything” by George F. Will in *Newsweek*, 5/23/06:

“Invited by the University of Miami to address the class of 2005, the columnist repaid this courtesy by telling them that even though they surely had showered before donning their caps and gowns, each of them had about a trillion bacteria feeding on the 10 billion flakes of skin each of us sheds in a day. If each graduate were disassembled into his or her constituent atoms, each graduation gown would contain nothing but atomic dust. But as currently assembled, this star dust—really: we are all residues of the Big Bang—is living stuff, capable of sublime emotions like love, patriotism and delight in defeating Florida State.”

“But there is a not-at-all-strange reason that a Washington columnist would belabor Miami graduates with strange facts. It is this: The more they appreciate the complexity and improbability of everyday things—including themselves—the more they can understand the role that accidents, contingencies and luck have played in bringing the human story to its current chapter. And the more they understand the vast and mysterious indeterminacy of things, the more suited they will be to participate in writing the next chapter.”

“This is so because the greatest threat to civility—and ultimately to civilization—is an excess of certitude. The world is much

menaced just now by people who think that the world and their duties in it are clear and simple. They are certain that they know what—who—created the universe and what this creator wants them to do to make our little speck in the universe perfect, even if extreme measures—even violence—are required.”

“America is currently awash in an unpleasant surplus of clanging, clashing certitudes. That is why there is a rhetorical bitterness absurdly disproportionate to our real differences. It has been well said that the spirit of liberty is the spirit of not being too sure that you are right. One way to immunize ourselves against misplaced certitude is to contemplate—even to savor—the unfathomable strangeness of everything, including ourselves.”

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## Health Savings Accounts a Tool, No Cure All

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From “Uncertain Cure: Early Reaction to Health Savings Accounts is Two-Sided” by Amy Goldstein in *The Washington Post*, 3/12/06:

“President Bush has begun to champion health savings accounts as a salve for the nation’s ailing health care system, proposing \$156 billion in tax breaks to encourage Americans to buy

an unorthodox kind of insurance that is favored by conservatives but whose merits are largely unproven.”

“Early studies of HSAs—and the early experiences of a small but growing number of people who are trying them—do not match the White House’s certainty that this recent concept in health insurance is, as Bush put it recently, ‘good for you.’ ”

“Health savings accounts differ sharply from traditional insurance by requiring people to pay more of

### RWHC Eye On Health



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

their own medical expenses in exchange for significant tax benefits if they set aside money for that purpose. The arrangement consists of two parts: an insurance policy—less expensive than most ordinary health plans—in which people pay at least a few thousand dollars up front before the coverage begins, combined with a special investment account into which they and sometimes their employers may save money tax-free for current or future medical expenses.”

“According to the White House and other proponents, the plans can tame medical costs, turn patients into smarter medical consumers and make insurance affordable for more people. HSAs, however, remain so new and rare that there is little evidence on whether they curb overall health care expenditures or overuse of care. Meanwhile, research hints that they are most appealing to people who are relatively affluent, not poor and uninsured.”

“Some people who have switched to the plans are delighted. Others have been disenchanted quickly.”

“Urged on by business, the banking industry and conservatives in Congress, the White House is defining HSAs as part of what Bush has called an ‘ownership society’ that shifts responsibility—and, critics say, risk—from government and employers to individuals. The budget the President recently recommended to Congress includes three tax breaks, totaling \$156 billion over the next 10 years, to encourage the use of health savings plans.”

“The plans became legal in 2004 under a bitterly contested aspect of a Medicare law. House conservatives insisted on allowing HSAs in exchange for supporting an expensive new drug benefit for older Americans; many Senate Republicans were less enthusiastic, and most Democrats fought the idea. The critics say HSAs mainly provide a tax break for people with good incomes and health, and create a dangerous ripple effect in which traditional insurance eventually would cost more for everyone else.”

“During the past two years, about 3 million Americans, out of 170 million with private insurance, have started to try them, according to insurance industry figures. Bush has said repeatedly that a third of people with such a plan were uninsured beforehand,

though two industry surveys suggest that is an overstatement. And though Bush has said that two-fifths of families with HSAs earn less than \$50,000 a year, research and some companies’ experience suggest the plans are most attractive to people who have relatively large salaries; people with modest incomes who have HSAs tend to be at small companies that do not provide a choice, early studies suggest. Most of the big employers that are trying HSAs offer them as one alternative, and they are much less popular.”

“A survey last fall by the Employee Benefits Research Institute found that people with HSAs were more likely than those with other health plans to delay or avoid care when they were sick. Neither that study nor any other has assessed whether such decisions are cost-effective or counterproductive.”

“The White House argues that Congress should give the proposal a chance. ‘If the market determines this is not a desired product, then so be it,’ said Trent Duffy, a spokesman for Bush. ‘Don’t let the politicians determine. Let the people decide.’ ”

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## Like Roosevelt: Reform the Market to Save It

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From “Why modest reform is preferable to single-payer health care” by Michael Kinsley posted at <http://www.slate.com> on 3/17/06:

“In the March 23 *New York Review of Books*, Paul Krugman makes the case for a health-care system that is not only ‘single payer,’ meaning that the government handles the finances, but in some respects ‘single provider,’ meaning that the government supplies the service directly.”

“Krugman and his co-author, Robin Wells, correctly diagnose the problem with the Bush administration’s pet health-care solution of encouraging people (with tax breaks, naturally) to pay for routine care à la carte instead of through insurance. Like Willie Sutton in reverse, this notion goes where the money isn’t. Annual checkups and sore throats aren’t bankrupting us: It’s the gargantuan cost of treating people who are seriously ill. People who can get insurance against



“What’s different about health insurance is the opposite: Much of it isn’t insurance at all but a subsidy. The

“Krugman and Wells say that private insurance is flawed by ‘adverse selection’: Insurance companies will avoid riskier customers. Only a single payer (that is, an insurance monopoly) can insure everybody and spread the risk. But anyone is insurable at some price—a price that reflects the cost they are likely to

impose on the insurer. Adverse selection is only a problem to the extent that insurance is not really insurance, but rather a subsidy.”

“If you’re not as hopeful as Krugman and Wells about being able to avoid rationing, you face the question: Should people be allowed to opt out of rationing if they can afford it? That is, if the system (private or single-payer) won’t pay for the \$100,000 pill, should you be able to pay for it yourself? Fear that this would not be allowed helped to kill the Clinton health-care reform 13 years ago. But explicitly granting some people life and health while denying these things to others is hard, even though this disparity has existed throughout history and is probably unavoidable. In fact, a serious defect of single-payer is that it makes all sorts of unbearable trade-offs explicit government policy, rather than obscuring them in complexities.”

“There are the makings of a deal here. Better-off or better-insured people could be told, individually or as a group: Give up your health-care subsidy, and you may opt out of any rationing-type restrictions that the system imposes. And if a few smaller reforms like that don’t work, maybe, it will be time for single-payer.”

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## Rural America is Not the Absence of Urban

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From “Redefining Rural America” by Thomas D. Rowley, a RUPRI Weekly Editorial, 4/12/06:

“In 17 years of studying the subject, I’ve come across nearly every definition of ‘rural’ there is. And there are plenty—from the bureaucratic to the bucolic to the downright bawdy (which my editors prevent me from sharing). At a pit stop on a long drive home last week, I even came up with one of my own: Rural is where gas station squeegees all have long handles so little old ladies can reach the bugs in the center of the 4x4 windshield. The beauty of that definition—if I do say

so myself—lies in the fact that it hits on three of the dominant factors of rural life: trucks, driving and the elderly.”

“The abundance of definitions, however, does not mean that rural America is well defined or well served. Indeed, it is neither.”

“As University of Illinois professor Andrew Isserman points out in the October 2005 issue of *International Regional Science Review*, researchers and policy-makers alike stumble when it comes to defining rural America. We have, says Isserman, no satisfactory way to measure rural. Instead, rural is defined in ‘two

different overlapping and often contradictory ways, always defined by what it is not—not urban, not metropolitan.’ Consequently, we misunderstand rural conditions, misdirect programs and funds and confuse everyone in earshot.”

“As one small but telling example, Isserman notes that one federal definition lists metropolitan America as home to both the Grand Canyon and more than a million farmers. Go figure.”

“Understanding that counter-intuitive factoid—and what can be done to bring it in line with reality—requires a brief visit to the world of federal data. So pour yourself another cup of coffee.”

“Two federal data systems underlie the vast majority of rural research and policy/programs in this country. One uses small geographic units called census blocks to identify urban areas of 2,500 or more people. Everything else gets called rural. The other system uses counties to identify metropolitan areas (and smaller micropolitan areas) that can be several counties wide and linked by commuting patterns—researchers and policymakers tend to refer to metropolitan counties as urban and, again, the leftovers as rural.”

“Insulting as it is for rural people and places to be regarded merely as a residual and defined primarily by what we’re not, the real damage comes from the huge

### **The Rising Tide of Health Care Consumerism**

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undercounting of rural people—undercounting that minimizes rural political clout, results in rural people and places being ineligible for rural programs and leads to all sorts of confusion about the actual needs and conditions of rural America. Indeed, 30 million rural people—the majority of rural people—live in so-called metropolitan counties (as do the Grand Canyon and those million-plus farmers). And because data for any unit smaller than the county is hard to come by, this second system is used most often.”

“Fortunately, says Isserman, there’s a better way—two actually. The ideal way would be for the ‘federal government to make available the same data for urban and rural areas that are available for counties.’ That’s possible, but would take some doing. The immediately doable alternative, what Isserman calls an ‘urban-rural density typology,’ would use existing county data in ways that recognize that most counties have both urban and rural areas. It would, in other words, reflect reality.”



## RURAL HEALTH CAREERS WISCONSIN

“Without going into the statistical details of the typology (and tanking up on even more caffeine), let me simply suggest that now is the time to get our definitions right. As Congress debates and formulates the 2007 Farm Bill and what hopefully will be the most significant

Rural Development Title ever, it needs to recognize that the best policies and programs in the world don’t count for beans if they don’t reach the people and places that need them. To be effective, programs must be accurately targeted.”

“As Isserman puts it, ‘...getting rural right is in the national interest. When we get rural wrong, we reach incorrect research conclusions and fail to reach the people, places, and businesses our governmental programs are meant to serve.’ ”

“We’ve been getting rural wrong for decades; it’s time to get it right. It’s time for a better, more accurate, more realistic definition of rural America.”

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