Rural Wisconsin Health Cooperative

Eye On Health

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

U.S.—Midwest Relations

From "Midwest Discovered Between East and West Coasts" in *The Onion*, a weekly newspaper, with an e-version at <**http://www.theonion.com**/>, 7/6/05:

"NEW YORK—A U.S. Geological Survey expeditionary force announced Tuesday that it has discovered a previously unknown and unexplored land mass between the New York and California coasts known as the 'Midwest.' "

"The Geological Survey team discovered the vast region while searching for the fabled Midwest Passage, the mythical overland route passing through the uncharted area between Ithaca, NY, and Bakersfield, CA."

" 'I long suspected something was there,' said Franklin Eldred, a Manhattan native and leader of the 200-man exploratory force. 'I'd flown between New York and L.A. on business many times, and the unusually long duration of my flights seemed to indicate that some sort of large area was being traversed, an area of unknown composition.' "

"The Geological Survey explorers left the East Coast three weeks ago, embarking on a perilous journey to the unknown. Not long after crossing the Adirondack Mountains, Eldred and his team were blazing trails through strange new regions, wild lands full of corn and wheat."

" 'Thus far we have discovered places known as Michigan, Minnesota and Wisconsin,' said Randall Zachary, chief navigator for the expedition. 'When translated from the local dialect into English, these words seem to mean 'summer camp.' "

"Eldred and the others were surprised to learn that the Midwest, whose inhospitable environment was long believed to be incapable of supporting human life, is indeed populated, albeit sparsely."

" 'The Midwestern Aborigines are ruddy, generally heavy-set folk, clad in plain, non-designer costumery,' Eldred said. 'They tend to live in simple, one-story dwellings whose interiors are decorated with Hummels and 'Bless This House' needlepoint wall-hangings. And though coarse and unattractive, these simple people were rather friendly, offering us quaint native fare such as 'hotdish' and 'casserole.' "

"Though the Midwest territory is still largely unexplored, early reports describe a region as backwards as it is vast. 'Many of the basic aspects of a civilized culture appear to be entirely absent,' said Gina Strauch, a Los

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"Despite the Midwesterners' considerable cultural backwardness, some say the establishment of relations with them is possible." (*The Onion*, 7/6/05)

Angeles-based anthropologist. 'There is no theater to speak of, and their knowledge of posh restaurants is sketchy at best. Further, their agricentric lives seem to prevent them from pursuing high fashion to any degree, and, as a result, their mode of dress is largely restricted to sweatpants and sweatshirts, the women's being adorned with hearts and teddy bears and the men's with college-football insignias.' "

"Despite the Midwesterners' considerable cultural backwardness, some say the establishment of relations with them is possible."

" 'Believe it or not, this region may have things to offer us,' said Jonathan Ogleby, a San Francisco-area marketing expert. 'We could construct an airport there, a place where New Yorkers could switch planes on their way to California. We could stage revivals of old Broadway musicals there. Perhaps we could even one day conduct trade with the Midwesterners, offering them electronic devices in exchange for meats and agriculture.' "

"Others, however, are not so optimistic about future relations. 'We must remember that these people are not at all like us,' Conde Nast publisher and Manhattan socialite Lucille Randolph Snowdon said. 'They are crude and provincial, bewildered by our tall buildings and our art galleries, our books and our coffee shops. For an L.A. resident to attempt to interact with one of them as he or she would with, say, a Bostonian is ludicrous. It appears unlikely that we will ever be able to conduct a genuine exchange of ideas with them about anything, save perhaps television or 'the big game.' "

Class Bias: Doing What Comes Naturally?

From "Minding about the gap," *The Economist*, 6/9/05:

"**America worries that it is becoming a class society. With reason**—For a people who pride themselves on ignoring social class, Americans are suddenly remarkably interested in it. The country's two leading newspapers are winding up blockbuster series on the subject. The *New York Times*', in ten parts, is called, simply enough, 'Class matters'. The *Wall Street Journal*'s offering, which will stretch to 'at least seven parts', is ostensibly about social mobility. But the series' conclusion is that social mobility has failed to keep up with widening social divisions: in other words, that class does indeed matter."

"America, of course, is rife with social distinctions, but it has always prided itself on the assumption that talented people are free to rise to their natural level. The country's favourite heroes have been Benjamin Franklin types who made something out of nothing. (The 15th child of a candle-and-soap maker, Franklin retired a wealthy man at 42.) And its favourite villains have usually been Paris Hilton types, who combine inherited wealth with an obvious lack of talent. 'The mass of mankind has not been born with saddles on their backs,' said Thomas Jefferson, 'nor a favoured few booted and spurred, ready to ride them.' "

"There was more to this than self-flattery. Foreigners have also been struck by America's social fluidity. In the 1830s, Alexis de Tocqueville noted the average American's 'hatred' of the 'smallest privileges'. In the 1860s, Karl Marx remarked that 'the position of wage labourer is for a very large part of the American people but a probational state, which they are sure to leave within a longer or shorter term'. In the 1880s, James Bryce noted America's talent for producing self-made men. Joseph Ferrie, an economic historian at Northwestern University, has crunched the census numbers from 1850 to 1920 and discovered that there was something to all this: more than 80% of unskilled men in America moved to higher-paying occupations, compared with less than 51% in Britain."

The **Rural Wisconsin Health Cooperative**, begun in 1979, is 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.

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"Today's America gives every impression of being more classless than ever. Shops such as Restoration Hardware and Anthropologie cater for the mass middle class in much the same way that Woolworths once catered for the mass working class. And Ivy League students dress more like rappers than budding merchant bankers. But beneath this bland surface, social divisions are getting wider."

"There is little doubt that the American social ladder is getting higher. In 1980-2002 the share of total income earned by the top 0.1% of earners more than doubled. But there is also growing evidence that the ladder is getting stickier: that intergenerational mobility is no longer increasing, as it did during the long post-war boom, and may well be decreasing."

"This is hardly the first time that America has threatened to calcify into a class society. In the Gilded Age, in the late 19th and early 20th centuries, the robber barons looked like turning into an English upper class. But this time round it could be much harder to restore the American ideal of equality of opportunity."

"The reason for this lies in the paradox at the heart of the new meritocracy. These days the biggest determinant of how far you go in life is how far you go in education. The gap in income between the college-educated and the non-college-educated rose from 31% in 1979 to 66% in 1997. But access to college is increasingly determined by social class. The proportion of students from upper-income families at the country's elite colleges is growing once again, having declined dramatically after the second world war. Only 3% of students in the most selective universities come from the bottom income quartile, and only 10% come from the bottom half of the income scale."

"**Clinging to privilege**—The obvious way to deal with this is to use the education system to guarantee a level playing field. Improve educational opportunities for the poorest Americans, make sure that nobody is turned away from university on grounds of financial need, and you will progressively weaken the link between background and educational success. Alas, there are at least three big problems with this."

"The first is that the schools the poorest Americans attend have been getting worse rather than better. This is partly a problem of resources, to be sure. But it is even more a problem of bad ideas. The American educational establishment's weakness for airy-fairy notions about the evils of standards and competition is particularly damaging to poor children who have few educational resources of their own to fall back on."

"The second is the politics of education reform. The Democrats have much deeper roots in poor America than the Republicans; they also have much greater faith in the power of government. But they are too closely tied to the teachers' unions to push for sensible reforms, such as testing and school choice. Their notions of improvement seem limited to pouring in more money."

"The third reason is the most powerful of all: that the educated classes still do such a superb job of consolidating and transmitting their privileges. This goes far beyond the *New York Times*' 'Sunday Vows' section, which lovingly chronicles the pairings of Princeton-educated bankers with Yale-educated lawyers at the very top of the tree. America's college-educated class is now a much larger share of the population than it was."

"The *New York Times* has supported its series on class with editorials condemning Mr. Bush's tax cuts. But even if the paper's argument is correct, it ignores the basic fact that so many people have become so good at passing their educational privileges on to their children. That is not something that is going to go away with a mere tweak of tax policy; after all, they are only doing what comes naturally."

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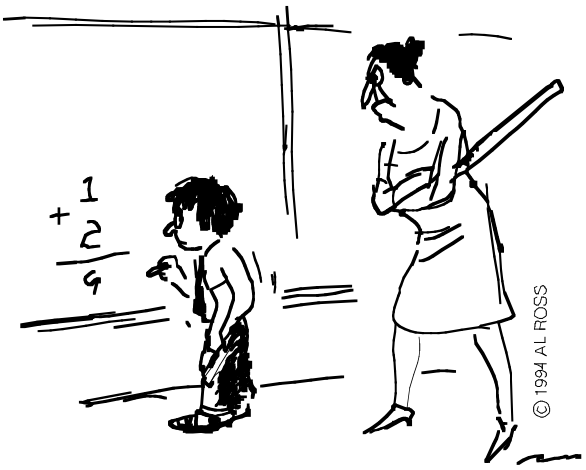


Folks against teaching evolution need to fight the reality of "Economic Darwinism"—that kids who have bad schools get bad jobs and have kids who have bad schools who…..

Health, Community & Race

From *Building Stronger Communities for Better Health* by the Joint Center for Political and Economic Studies with PolicyLink, supported by a grant from the W.K. Kellogg Foundation. The 2004 policy brief is available at <**http://www.policylink.org/**>.

"The problem of health disparities—specifically, the higher incidence of certain diseases and health conditions among communities of color—first emerged on the national policy agenda in 1998. Community leaders, public health officials, and an array of state and national organizations seized on the issue, seeking to educate policymakers and the public and advocating for an expansion of policy initiatives across the country. Such efforts have focused most often on expanding access to health care and improving individuals' experiences within the health care system."

"Improving access to health care and the quality of that care remain critically important and challenging goals. But research on the causes of illness and mortality in the United States suggests that improving health care and health outcomes in communities of color would be most successful with a simultaneous focus on those communities' social, economic, and physical environments. Far from being a mere backdrop for interventions designed to change individual health and health behavior, community environments must be understood to have equal importance."

"This issue brief presents a framework for understanding how community conditions affect individuals' health both directly and indirectly. It discusses how attention to these determinants of health requires a shift from a narrow focus on treatment to a broader approach that includes prevention and health promotion. The overarching roles that race, ethnicity, and socioeconomic status play in health status are explored within this context, and the case is made that the legacy of racism must be addressed if the continuing health disparities between white Americans and Latino and African Americans are to be eliminated."

> "When it comes to diet and nutrition, it isn't any single influence. The absence of safe and affordable exercise venues in our neighborhoods and the lack of promotion of exercise in schools, together with targeted advertising for unhealthy foods, affect young people's ability to choose healthier lifestyles."

> "Everyone is focused on health behaviors these days, but the environment people are constrained within far exceeds the effect of any individual change. Our program can link kids to asthma specialists and ensure they have the right medicines and resources like bed covers, but at the end of the day, if they go housing that is roach infested, and moldy, we will not be able to stabilize their asthma."

"Included are key findings from our interviews with African American and Latino elected officials and community health leaders. Their discussions also suggest that resolving health disparities will require making changes in community environments. The final sections of this brief discuss the implications of this community-effects concept for designing new policy and program strategies. According to the interviews, such changes will require approaches—ranging from local neighborhood action to securing public funding and effecting policy changes—that will not be easy given current fiscal and political constraints. Nonetheless, the interviews, current research, and the experiences of African Americans and Latinos all underscore the need for continued leadership and action in the effort to improve the health status of these populations."

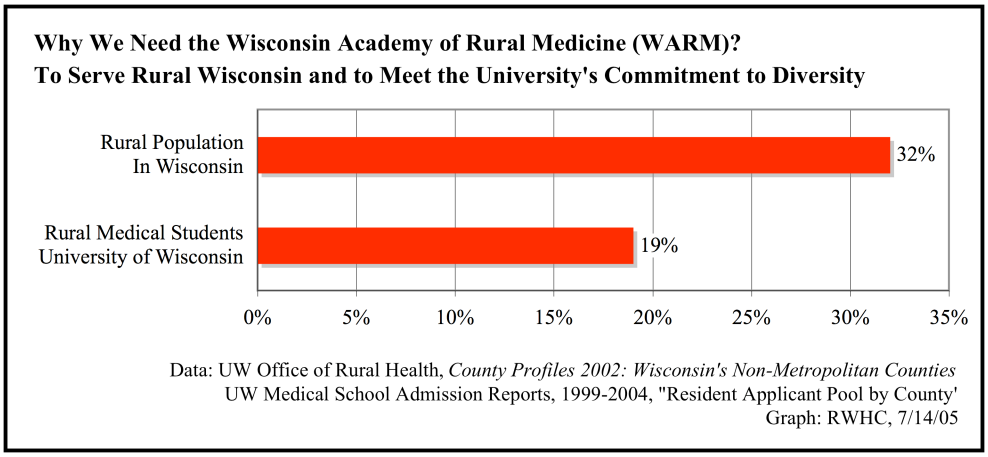
Physician Shortage Hits Rural First & Worst

From "Workforce Report 2005, Doc shortage gets noticed" by Michael Romano in *Modern Healthcare*, 6/13/05:

"The pendulum has swung in the great doctor-supply debate. After years of warning about an overabundance of tens of thousands of physicians in the new millennium, the typically conservative medical community is now listening to experts who, for years, have been predicting a looming undersupply of doctors."

"The Association of American Medical Colleges, which represents the nation's 125 accredited medical schools, issued a report three months ago calling for a 15% increase in medical students, or about 2,500 per year, by 2015. The Council on Graduate Medical Edu-

cation recently came to the same conclusion. Even, the American Medical Association, which argued for years against an increase in the ranks of the nation's doctors, is set to debate a hike in supply when it gathers in Chicago late this week for its annual meeting."



"The big question is: Will educators, the medical community and public policymakers come to a consensus and address this issue in time to make any real difference?"

" 'This is an urgent concern right now,' says Edward Salsberg, director of the 14-month-old Center for Workforce Studies at the AAMC, which hosted the first national conference on this topic last month in Washington. 'And why it's urgent is because of how long it takes to create new medical schools, change supply and distribution and train new doctors. We need to be concerned about the year 2015 because we can't wait for 2015 to say, *Who's going to care for the baby boom generation?*"

"He noted that the number of Americans age 65 and over will swell by 35 million by 2030, increasing utilization for the kinds of expensive medical treatment most often associated with the elderly, including heart disease, cancer, pulmonary disorders and diabetes. Meanwhile, doctors appear to be working less and retiring earlier, while the U.S. population has grown."

" 'We can't rely solely on waiting for signals from the marketplace that we need more,' Salsberg says. 'If somebody could definitively say today that we need X number of physicians, it would take us 10 years to produce them.' "

"Richard Cooper, a physician who is the director of the Health Policy Institute at the Medical College of Wisconsin in Milwaukee and another national expert on physician-workforce issues, says the conference helped reinforce the 'broad consensus that we're in the middle of a deepening shortage of physicians and we need to do something about it.' He suggests, however, that the shortage will be far more acute than predicted by the AAMC."

"Cooper criticized Salsberg, a longtime colleague, and the AAMC in general, for what he calls a tendency toward understating the urgency of the future shortage—and thus minimizing the national reaction to the problem. He is certain the shortage will be much worse than Salsberg estimates and says he believes it takes a worst-case scenario to generate an adequate response from policymakers."

"The problem with (the AAMC and Salsberg's estimates) is that they've undershot (the real shortage) to such a degree it will mislead the nation—it's deplorable. They've come up with a figure that leads to complacency. You don't energize a response by minimizing a problem.' "

"The AAMC's two-day physician-supply conference, which attracted dozens of researchers, educators and doctors, was the first step in underscoring the importance of sharing information and working toward a common goal, Salsberg says. For too long, he adds, researchers from many different arenas-including the federal government and the medical community-have worked 'in their own silos,' rarely sharing data."

"We've had lots of bits and pieces,' he says. 'But there's never been a real focus on this kind of research by a group like the National Institutes of Health or the Centers for Disease Control. There is no systematic national funding for physician-workforce planning.' "

"While there are plenty of projections of what the supply might look like a decade from now, Salsberg says it's increasingly important for overall planning and strategy to determine, for example, if doctors are retiring earlier than usual or working less than their

counterparts in the past. That kind of information is a key piece of the puzzle when policymakers begin to sort through future needs."

"Amid the growing acceptance of a future physician shortage, Salsberg says he expects to see the number of medical students increase by 15% through a combination of a slight enrollment boost in existing schools and the addition of 'six or seven' new medical schools over the next five years."

"Yet, even those increases might not be enough to meet demand, Salsberg says. In his presentation at the AAMC meeting, he pointed out that the 15% hike would add about 30,000 new doctors to the supply by 2020, bringing the total to just more than 1 million. That, he says, is far less than the 'likely demand' of as many as 1.24 million physicians 'if services in 2020 are delivered as they were in 2002.' "

Medical Schools' Rural Attitude Matters

From "Physicians for Rural America: The Role of Institutional Commitment Within Academic Medical Centers" by John Wheat, MD, MPH et al, *Journal of Rural Health,* Summer 2005. The complete article will be available shortly at <**http://www.nrharural.org**>.

"Rural populations remain at the margin with respect to access to many of society's amenities. Developments in education, technology, economics, and social attractions aggregate predominantly in urban and suburban areas, with little assurance of passive diffusion or extension to rural areas. The burden and expense of accessing these societal resources rest more heavily on rural citizens whose desire for equity would appear justified, in part by their contribution to the public funding that often supports such developments."

"Modern physicians are cherished societal resources. Their educational development is largely an urban undertaking and their diffusion into rural areas does not keep pace proportionately with the rural segments of the population. Since the 1960's, rural constituents have maintained public pressure to increase the number of doctors who choose to serve in rural areas. Academic medical centers often are the focus of this pressure, but have been slow to turn scientific inquiry inward and to study their own effectiveness in meeting the need for physicians within their constituent populations."

"**Context**—Prior study suggests that contextual characteristics of medical schools (e.g., state demographics, public vs. private, NIH research effort) predict output of rural physicians without also considering the effects of the medical schools' own policies and programs."

"**Purpose**—This study examines medical school commitment to rural policies and programs and its relationship to contextual characteristics and rural physician output. Methods: A survey of 122 US allopathic medical schools provided data to construct a 32-item Rural Commitment Index for each medical school."

"**Findings**—Among 90 medical schools (response rate, 73.8%), the Rural Commitment Index correlated with the percentage of the state population that is rural and whether the school is public or private, and it joined percentage state population rural, public vs. private, and National Institutes of Health support in correlating with percentage of graduates in rural primary care. In a regression model that explained 48.4% of variation in the percentage of graduates in rural primary care, the Rural Commitment Index explained most variation, followed by percentage state population rural, public vs. private, national Institutes of Health support, and the interaction between the Rural Commitment Index and public vs. private."

"**Conclusions—The findings support the proposition that observable institutional commitment affects rural physician output** and provide justification for a definitive study to verify that a change in medical school commitment to rural medicine produces a change in rural physician output."

CAHs Mirror Overall Hospital Trends

From *Scope of Services Offered by Critical Access Hospitals: Results of the 2004 National CAH Survey, Flex Monitoring Team Briefing Paper No. 5, 3/05* at: <**http://www.flexmonitoring.org/**>.

"We used three years of national survey data (2000, 2002, 2004) to examine the scope of services offered by Critical Access Hospitals (CAHs). We investigated how the services offered by CAHs have changed, the role of network affiliations in these changes, and the reasons administrators gave for reported service expansions. With three years of survey data, we also examined how services offered have changed over time."

"Most CAHs offer a core of services including radiology, laboratory services, emergency rooms, swing beds, pharmacy, outpatient rehab, outpatient surgery, and specialty clinics. While this core has not changed significantly over the period of three surveys, many CAHs have added or expanded services not dependent on inpatient capacity. Of the 474 CAHs surveyed in 2004, at least 20% added or expanded radiology, specialty clinics, outpatient rehabilitation, and laboratory services, while others commonly added or expanded outpatient surgery and rural health clinics. Of the 540 CAHs surveyed during the three survey years, at least one quarter added or expanded radiology, specialty clinics, outpatient rehab and laboratory services."

"In 2004, CAH administrators were asked the reason they changed the services offered. For over half of the added or expanded services, the majority of administrators reported that community need was the reason for these expansions. For services requiring specialized staff, including surgery and obstetrics, the majority of administrators added or expanded the services because they had the clinical staff available to provide these services. Increasing hospital revenue was the primary reason for only three services (rural health clinics, federally qualified health centers, and swing beds), while improving quality was the most common reason for only one service, pharmacy."

"Many CAHs also expanded surgical services. In 2000 and 2004, CAH administrators were asked how many surgical procedures were performed at their hospitals. Fifty-four offered inpatient surgery and 90 offered outpatient surgery in both years. The average annual number of inpatient surgical procedures has changed little over time, but outpatient surgical volume has increased steadily. Of the 90 hospitals performing outpatient surgery in 2000 and 2004, 40 had at least a 10% increase in outpatient surgical volume between 2000 (post-conversion) and 2004. However, nearly as many hospitals had decreased their outpatient surgical volume by 10% or more during this time period. This volatility in surgical volume may be explained, at least in part, by additions and losses of medical staff."

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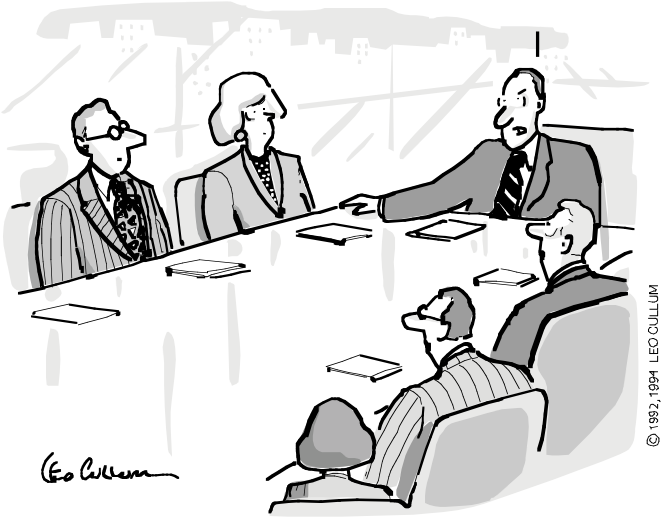

"The only 'limited hospital" thing about us,
is the vision of our critics."

"In previous years (2000 & 2002), we found that organizational linkages, such as system membership or network affiliation, had a significant impact on whether hospitals added or expanded the services they offered. In the 2004 survey, we did not find this relationship, with system membership or network affiliation having little influence on whether CAHs added or expanded services. However, hospitals having a mutual agreement for specialty services with another health care organization were significantly more likely to have added or expanded specialty clinics. Expansion of outpatient services by CAHs mirrors a similar trend in larger hospitals, both urban and rural, and is probably not directly attributable to the Flex program. The identification of community need as a primary influence on service expansions is a promising indicator of community-oriented strategic planning by CAH administrators and their boards."

The Technical Assistance and Services Center (TASC) provides technical assistance for Critical Access Hospitals—information, tools and resources. Go to <http://tasc.ruralhealth.hrsa.gov/>.

Malpractice Caps Help Rural Communities

Note: On July 14th, a Wisconsin Supreme Court ruling found Wisconsin's existing cap on non-economic damages associated with medical liability unconstitutional.

From "Have State Caps on Malpractice Awards Increased the Supply of Physicians?*"* by William E. Encinosa and Fred J. Hellinger, a *Health Affairs Web Exclusive*, 5/31/05:

"Twenty-seven states have laws that cap payments for noneconomic damages in malpractice cases. In this study we examined whether these laws have increased the supply of physicians, using county-level data from all fifty states from 1985 to 2000. Counties in states with a cap had 2.2 percent more physicians per capita because of the cap, and rural counties in states with a cap had 3.2 percent more physicians per capita. Rural counties in states with a $250,000 cap had 5.4 percent more obstetrician-gynecologists and 5.5 percent more surgical specialists per capita than did rural counties in states with a cap above $250,000."

"Data from U.S. counties indicate that rural areas feel the effects of caps most acutely and that the amount of the cap matters."

"In this study we found that state caps on noneconomic damages awards in malpractice suits between 1985 and 2000 increased the supply of physicians. Moreover, the caps had a larger impact on physician supply in rural counties, and caps limiting malpractice awards to $250,000 had a much larger effect on surgeons and OB-GYNs in rural areas than caps with limits above $250,000. Twenty-seven states have caps on malpractice awards, but only five have caps with a $250,000 limit on awards, and 40 percent of the U.S. population living in a state with a cap has one with a limit above $400,000. Thus, a federal cap set at $250,000 for noneconomic damages could have a beneficial impact on the supply of surgeons and OB-GYNs in rural areas."

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