Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – June 1st, 2006

The Price of Rural Health Care

This editorial is by Thomas D. Rowley, a Fellow at the Rural Policy Research Institute; his columns can be found at **http://www.rupri.org/editorial**

"As Thomas Jefferson once said, 'The price of freedom is eternal vigilance.' So, apparently, is the price of rural health care."

"In a depressing but not surprising rerun of last year's budgetary drama, President Bush has once again cut programs that provide health care to millions of rural Americans—this time by 83 percent. Among the programs on the chopping block are those that help hospitals, clinics and other providers work together to reach underserved people and provide higher quality care to all."

"I say 'drama,' because last year it took an eleventh-hour effort by a handful of House members to restore (albeit only partially) funds for rural health. Indeed, the move by six Republicans, against the party line, halted the multi-billion dollar appropriations bill for the Departments of Health and Human Services and of Labor—all in the name of preserving rural health. One Washington insider described the bold feat as 'pretty freaking amazing.' "

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"He can't accept it makes no sense to fund those who can't afford to attend our fund raisers."

"The question now is how much drama we'll have this year? Will Congress stand up early for rural Americans? Will it once again wait until the last minute and rely on a brave few? Or will it allow the cuts to go through and rural Americans to suffer?"

"The Senate has already voted in its budget resolution to fully fund all rural health programs. The plotline in the House isn't so straightforward. Though not yet passed, the House budget resolution toes the President's hard fiscal line. What really counts, however, are the spending bills that will come later this year (appropriations subcommittees start work this week). That's when we'll know whether and by how much funding that ensures that rural Americans have access to affordable, quality health care will be cut or restored."

"The other big question in all of this is why? Why the cuts to rural health care? Cuts that go way beyond the across-the-board belt tightening we've come to expect in order to pay for two wars and big tax breaks. Cuts that last year brought howls of protest from the rural health crowd, something my Washington insider described as 'rural finally playing hardball.' Why would Congress and the White House again risk such chastening? In an election year no less?"

"The administration's stated rationale is that increases to Medicare back in 2003 more than make up for the cuts. But according to National Rural Health Association CEO Alan Morgan, that's apples and oranges. The Medicare increases, he says, reimburse providers to ensure that existing care continues to be available in rural areas. The programs being cut now are about increasing the reach and improving the quality of care."

" 'That basic concept,' he told me, 'is not catching hold with this administration.' On top of that—and the faulty logic of equating unequal things aside—many of the Medicare increases are set to expire soon. How will they help then?"

"In cutting other programs, the Administration has cited poor performance as measured by the Office of Management and Budget's Program Assessment and Rating Tool, PART for short. The problem here is that the rural health programs are, in fact, judged to be performing adequately. So, not only do we have drama, we also have mystery."

"Fortunately, the story's ending is not yet written. Rural advocates can—as last year—influence the outcome. Doing so, however, will require staying abreast of developments as bills move through Congress and letting the story's legislative authors know what we think and want. As with freedom, the price of programs we believe in, is vigilance."

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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Trust Counts Now More Than Ever

The following is the Forward by Dick Davidson, American Hospital Association (AHA) President, from *TRUST COUNTS NOW, Hospitals and Their Communities,* a report to the AHA by John G. King and Emerson Moran; the 24 page report is online at:

http://www.caringforcommunities.org/caringforcommunities/content/trustcounts.pdf

"The document in your hands has the potential to help you awaken your board and management team to one of the most important and pressing priorities for America's hospitals: reaffirming their rightful place as valued and vital community resources that merit broad public support. *Trust Counts Now* is a report by a nationally recognized leader on the relationship between hospitals and the communities they serve."

"The American Hospital Association's Board of Trustees believe that strong public trust and confidence is the key to a successful future for every hospital. And they share a commitment to helping AHA members strengthen that bond in any way they can."

"The Board asked their respected colleague, former AHA Chairman John G. King, to take on what for some might be an intimidating task: assess the many forces and factors affecting public trust and confidence, find out what leaders across America were thinking about the issue and see which institutions were creating models of community connection."

"John led three health care organizations during his distinguished career, retiring as chief executive of Legacy Health System in Portland, Oregon. He currently is on the board of The Health Forum and is a member of the AHA Center for Healthcare Governance Board of Managers. Since his retirement, many hospitals and health systems have sought his counsel on strategy, governance and other issues. The report he delivered to the AHA Board of Trustees is a straight-from-the-shoulder, sometimes jolting analysis of what the public and hospital leaders are worried about, what some hospitals are doing about it, and how others can and should follow."

National Rural Health Association

30th Annual Conference: May 16-18, 2007

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"To get this information, John, with the help of Emerson Moran, former head of advocacy communications at the American Medical Association, conducted a series of intensive and candid interviews with hospital leaders from all areas of the country and discovered and described several examples of hospitals working to cement their community bonds in innovative ways. They also compiled information from various public opinion polls about hospitals, including the AHA's own Reality Check series of focus groups."

"If you want to know how hospitals are hardwiring public trust and confidence into their mission, strategic planning and everyday work through the very organizational model that holds them together, this report is vital reading. It points to best practices for how to earn and bolster public trust. And it all adds up to some very sharp observations about how our moral compass should lead the way."

"After you've read this, I'll bet you will quickly develop your own list of others on your team with whom you'll want to share it. It illuminates some very critical lessons about the bond that exists, or should exist, between you and the community you serve. As John says in the close of this report, 'energy and openness' are needed if hospitals are to regain the trust of the public – the same energy and openness that grace this important document."

"Local-Market Bias" or Healthcare Offshore?

From "How Health Insurance Inhibits Trade In Health Care" by Aaditya Mattoo and Randeep Rathindran in *Health Affairs*, 25, no. 2 (2006): 358-368:

"A range of health care services are tradable, in that consumers can travel abroad for treatment. In this paper we first estimate the gains from trade. An international price comparison of fifteen procedures reveals that there could be savings of around $1.4 billion annually even if only one in ten U.S. patients choose to undergo treatment abroad. We then identify a key impediment to realizing these gains: the nature of existing health insurance plans, which discriminate explicitly or implicitly against treatment abroad. We propose that coverage should be neutral to provider location and that reimbursement should include travel costs."

"Is health care so different from other goods and services that it cannot be regarded as tradable? Consumers certainly value both proximity and quality, but that has not prevented them from traveling abroad to obtain various treatments, such as cosmetic surgeries, rehabilitative care, alternative medicine, and even eye and cardiac surgery. In 2003 an estimated 50,000 British medical tourists traveled to Thailand, South Africa, India, and Cuba for a variety of treatments."

"The high cost of health care in the United States relative to that in a number of other countries would seem to provide a strong incentive for trade. For example, an inpatient knee surgery, roughly 400,000 of which are performed annually in the United States, costs more than $10,000 there but less than $2,000, including travel, at the best hospitals in Hungary and India. We estimate that even if only one in ten patients who need one of fifteen highly tradable, low-risk treatments went abroad, the annual savings for the United States would be $1.4 billion. But surprisingly few Americans travel abroad for treatment."

"Most travel is for procedures not adequately covered by home-country health insurance; this suggests that a key impediment to trade is the nature of existing health insurance plans. We find that most plans do not cover treatment abroad; if they do, the consumer must bear the full costs of travel and obtains only a fraction of any cost savings. Since the costs of travel are usually greater than any out-of-pocket savings, the adequately insured have little incentive to travel, which results in a strong 'local-market bias' in the consumption of health care."

"There is a simple solution: The terms of insurance coverage should be neutral to the location of the provider, and reimbursement should be based on the costs of treatment inclusive of travel costs. This would be sufficient to ensure that the consumer has

an incentive to travel if, and only if, there were any gains from trade."

"The realization of gains from trade hinges on the consumer's willingness to travel abroad for health care. There are a number of myths about trade in health care. Here we address two."

"**Myth 1: The sick cannot travel, so care must be delivered at home.** It is certainly true that many types of treatment must necessarily be delivered close to home: emergency care following an accident, or when patients are physically incapable of travel. However, for many treatments, such as hernia repairs or eye surgery, the patient can both wait and travel for treatment. That these are not merely hypothetical possibilities is revealed by the growing volume of 'medical tourists.' Estimates suggest that in 2003, more than 350,000 patients traveled to Cuba, India, Jordan, and Southeast Asia specifically to seek care. A sizable number were patients from industrialized countries, traveling to a growing number of high-end overseas hospitals to obtain 'first-world treatments at third-world prices.' "

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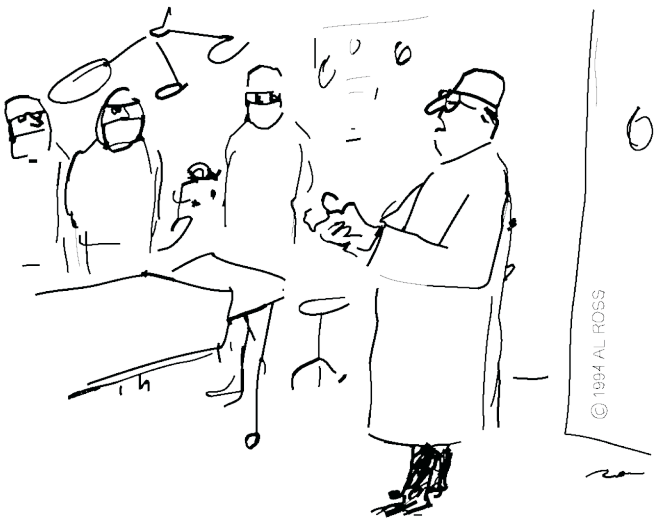

"As we can't cost shift offshore, we need to get healthier patients."

"**Myth 2: The quality of care available in developing countries is lower than in industrialized countries.** This statement is certainly true on average. The relevant comparison, however, is not with the standard of an average developing-country provider but with the standard of a provider likely to be used by a patient from an industrialized country."

"First of all, a sizable number of foreign-educated medical professionals have been deemed to be adequately qualified to practice in the United States. International medical graduates now account for a quarter of the 853,187 U.S. physicians. Interestingly, the top eight countries of origin of foreign physicians in the United States are all developing countries, with Indian-educated physicians constituting the largest group (21 percent), followed by those educated in the Philippines, Cuba, Pakistan, Iran, and Korea.[4] Also, foreign-graduate faculty now account for almost a fifth of total U.S. medical school faculty members. Moreover, the share of foreign-educated nurses among newly licensed registered nurses in the United States has been rising since 1998, exceeding 14 percent in 2003. Filipino nurses dominate the numbers of foreign nurses at 43 percent, followed by nurses from Canada, the United Kingdom, India, Korea, and Nigeria."

"Further, the Bumrungrad (Bangkok), Apollo (New Delhi), and Crossroads Center (Antigua) are all examples of reputable medical facilities in developing countries that are comparable to the best in industrial countries. These facilities treat many foreign patients annually, have internationally trained physicians and nurses, and maintain high surgical success rates. For example, the Apollo hospital chain has reportedly maintained a success rate of 99 percent in more than 50,000 cardiac surgeries performed, which is on par with the surgical success rates of the best U.S. cardiac surgery centers."

Price Transparency Needs to Lose Cataracts

From "Shopping for Healthcare Prices Can Be Pretty Confusing" by Julie Appleby, *USA TODAY*, 5/9/06:

"From the president of the United States to the president of the biggest employer in town, it seems as if everyone is urging Americans to become better 'shoppers' for health care."

RURAL HEALTH FELLOWS PROGRAM
NATIONAL RURAL HEALTH ASSOCIATION

The Rural Health Fellows (RHF) program is a year-long, intensive program that will develop leaders who can articulate a clear and compelling vision for rural America. The NRHA has partnered with Healthcare Performance Solutions, a company with experience training rural health care providers to become leaders, to provide appropriate content for the Rural Health Fellows program.

Fellows will gain valuable insights and build critical skills in three primary domains: 1) Personal, team, and organizational leadership; 2) Health policy analysis and advocacy; 3) National Rural Health Association governance and structure.

Program Charter

- To identify and develop individuals who share a passion for rural health policy at the local, state and national levels.
- To create and build a community of leaders who will work individually and collectively to advocate for the health care needs of rural communities.
- To develop growing levels of leadership skill and advocacy competence that will translate into action and results on rural health policy issues.
- To educate, develop and inspire a networked community of leaders who will step forward to serve in key positions in the National Rural Health Association, affiliated rural health advocacy groups, and local and state legislative bodies.

More information and the application form is available at:

http://www.nrharural.org/groups/sub/fellows.html

"Get a high-deductible insurance plan. Open a health savings account. Call around and find the best deal on medical treatments, then pocket the savings. Sounds great: but just try it. Even as some employers, insurers and politicians tout consumerism in health care as the newest and best way to control rapidly rising medical inflation, it's still exceedingly difficult to be a medical care consumer."

"Most hospitals and doctors can't or won't quote a price for care. Quality information — such as mortality and complication rates — is available for some hospitals and some procedures, but information on individual doctors is rare."

"Even when prices are quoted, the data given might be nearly useless if they reflect 'charges,' which few people pay, rather than actual negotiated rates."

"Nationally, few consumers try to shop or negotiate on price. Only 11% of adults say they had negotiated with a doctor, hospital or other health care provider to try to get a lower price, according to a Kaiser Family Foundation, Harvard and *USA TODAY* poll last year."

"But that is slowly changing, driven in large part by employers' push to get insured workers to pay more attention to cost. Like it or not, the focus in controlling rapidly rising health care spending is now on the consumer. Benefit analysts and organizations such as the Kaiser Family Foundation that survey employers say insured patients are going to spend more of their own money, not just on premiums, but every time they go to the doctor, pick up a prescription or get admitted to the hospital."

"Proponents of making price and quality data public say it will spur a more marketplace approach to health care as medical providers see what others are charging—and try to remain competitive—and patients who have to spend more of their own money on deductibles and co-payments select the more cost-efficient providers."

"Others are skeptical, saying health care might never be a true marketplace. 'One of the false notions ... is that only if providers fess up about their true prices can consumers get the kind of choices they find at Travelocity and CarMax,' says an editorial in the March 27 issue of *Modern Healthcare*, a trade magazine covering the hospital and health industry. 'The reality is that the most costly health care decisions are made by sick, scared patients in emergencies.' "

"Some say the debate is larger than simply a discussion about price, but more a reflection on the type of insurance people want or are offered."

" 'It's not about whether consumers should shop for health care like plasma TVs,' says Drew Altman of the Kaiser Family Foundation. 'It's about two fun-

damentally different approaches to health care: comprehensive and less comprehensive with high-deductible plans. Which does America want?' "

"Sometimes patients can't shop: riding in the back of an ambulance is no time to do price comparisons."

"Still, even when consumers know ahead of time that they'll need a specific treatment, prices quoted by those hospitals, doctors and private data firms that do provide them are often based on an average or some other measure that might not be relevant, especially for those with insurance."

"HealthGrades, a private firm that sells data on prices for 55 different treatments, acknowledges that the prices it quotes are averages—and are not specific to any one hospital—but they are based on information about what insurers paid for the services."

"A typical report, which sells for $7.95, shows how much the patient would pay, how much the health plan might pay, as well as the total list price of a procedure, which is roughly equivalent to 'charges.' Knee-replacement surgery for a 45-year-old woman in the Northeast, for example, lists for $44,514, according to HealthGrades. But a typical health plan, after negotiating a discount off of the list price, would pay $18,269. The patient, who pays 20% of the bill, would be responsible for $3,654."

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"So maybe the price guide wasn't very specific."

"Such information might be a starting point for an uninsured patient or one with a large deductible. But most patients with insurance might find the information not relevant to their particular policy."

"Supporters of high deductibles, including John Goodman of the National Center for Policy Analysis, say people who must use more of their own cash for care will be more judicious users of medical services. Goodman and others want more price and quality data available because, without it, people cannot shop."

"But even with pressure from employers and the government, it'll take time for useful data to be available. 'We are probably three to five years away from having that information in a way consumers can really use it,' says Peter Lee of the Pacific Business Group on Health, a coalition of employers on the West Coast."

The Case for Consumerism from the Trenches

From the Neillsville Memorial Medical Center *Employee Newsletter* by Glen Grady, CEO, 5/06:

"I think all of us like amazing facts—I like the ones that just are—that I can't do anything about and that I feel no responsibility for—like 'over half the coastline of the United States is in Alaska' or that 'Istanbul is the only city in the world located on two continents.' Kind of cool stuff—not mind wrenching or scary—just stuff. Things that are true but don't really matter to us and are not going to affect our life or lifestyle."

"But I read a few facts the other day that are much more scary and upsetting. And, although we probably can do little individually to change them, we are all part of the problem and sooner or later will have to be part of the solution."

"Got milk? Wisconsin is losing, on average, four dairy farms a day due to inaccessible or unaffordable health care. Got coffee? Remember when a cup of coffee cost a quarter? The next time you buy a cuppa jo, realize that much of what you are paying for is health care premiums. In fact, the price of health care for Starbucks employees now exceeds the cost of its coffee. Got gas? Maybe you can keep up with the price of

gasoline, but how long will you be able to afford a car? The cost of health care for the retiree program (retirees only) for General Motors now exceeds the price tag for the steel it buys to produce cars. Got a job? American businesses of all types are pleading for help in controlling health care premium costs."

"This are snippets of the summary in May's *Business Magazine for Greater Madison* Healthcare Roundtable experts' discussion of health care cost and their urgent search for answers to what is rapidly becoming a crisis of mammoth proportion."

"For me and, I imagine, for all of you it has become an all too familiar theme at work and at home. Almost every other thing I read and write speaks to this crisis. Yet government and health care industry experts don't seem to be making much progress in trying to control what seems like an industry in a death spiral, a spiral that is beginning to lay waste not only to itself, but also many other segments of the American economy."

"One of the drivers of excessive health care cost is obvious and has been around for a long time. It seems that everyone wants to franchise—take ownership of—profitable patients, especially patients with good insurance and/or money that need specialty (which in this industry translates into 'profitable procedure') care. And the reason they want to do this in not just hubris. It makes sense. It isn't all that altruistic and may ignore other community health care needs, but it makes money."

"Strategies to franchise paying patients have taken many forms over the last thirty plus years. Honestly and unfortunately, they all have lead to duplication and thus excess capacity. And excess capacity naturally drives equipment, employment and other costs beyond what might be considered reasonable and necessary."

"However we may be starting to see consumerism play a role in health care decision making and thus in utilization. There is a perceptible down turn in primary care utilization in many areas where high deductibles have been introduced either through employer health plan design or heavy marketing of health savings accounts. While some of this reduction may be for services that should have been used, it does indicate that who is paying the bill matters."

"This could start to reduce the amount of over utilization in the health care system and eventually should effect duplication of services. The expensive stuff and the stuff that makes money is at the tertiary level of the health care system, so it will take a lot of time before this movement can really start effecting the core of the health care cost equation. Still it is nice to know that there is at least one problem were government and so called experts solutions are trumped by the good sense of the American consumer."

WI Leaders Receive Top National Honors

Each year the National Rural Health Association recognizes six or seven individuals and organizations for an outstanding contribution to rural health. This year, at the 29th annual conference in Reno, two of the honorees were from Wisconsin.

The 2006 Distinguished Educator Award went to Byron J. Crouse, MD, at University of Wisconsin. The 2006 Quality Award went to the Memorial Health Center in Medford, Wisconsin and was accepted by Rosalyn Haase, RD, CDE, MPH, the hospital's Diabetes Education Program Coordinator.

Distinguished Educator Award: Dr. Byron Crouse

"Dr. Crouse has trained countless physicians and health care professionals who now provide the foundation of health practice in rural communities. His life's work proves that education and curriculum development dedicated to the needs of rural health professionals has the potential to encourage, assist, enhance, expand, and improve rural health careers."

"Dr. Crouse served as a private practice physician and was the first chair of the Department of Family Medicine at the University of Minnesota, Duluth School of Medicine. There he lead the development of the Minnesota Rural Health School, an interdisciplinary activity involving primarily medicine, nursing, pharmacy, and social work."

"Dr. Crouse is now the Associate Dean for Rural and Community Health at the University of Wisconsin School of Medicine and Public Health where he began the Wisconsin Longitudinal Rural Rotation."

"Dr. Crouse is also beginning a new initiative in Wisconsin to address rural physician shortages in the state, the Wisconsin Academy for Rural Medicine. The program will increase the medical school class size by about 17% with the increase being students with an affinity for rural practice. The curriculum will enhance the traditional class offering at the University by adding rural-oriented content that will take place in rural settings."

Quality Award: Medford Memorial Health Center

"Memorial Health Center (MHC) had a goal to improve hemoglobin A1c outcomes among diabetic patients and to improve frequency of testing hemoglobin A1c levels. MHC adopted the International Diabetes Center's Staged Diabetes Management (SDM) Practice Guidelines to improve diabetes care practices among providers, and implemented an American Diabetes Association (ADA) Recognized Education Program that included medical nutrition therapy by registered dieticians to improve diabetes self-care knowledge, skills and behaviors among patients."

"After five years of adherence to SDM guidelines and algorithms, offering patients comprehensive diabetes self-management education including dietitian services, as well as implementing process improvements consistent with SDM; including the creation and use of a diabetes flow sheet, the implementation of a diabetes registry, the formation of a diabetes care team, and the incorporation of visit planning and standing orders; MHC achieved an average hemoglobin A1c level under 7.0 for over 550 diabetic patients."

"In 2003, these efforts resulted in achieving number one county status in Wisconsin for frequency of hemoglobin A1c testing. Memorial Health Center's service area counties continue to consistently lead Wisconsin in A1c testing, lipid testing & retinal eye exams."

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