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Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – February 1st, 2013

For Health: Care Necessary But Not Sufficient

From "Americans Die Younger Than Peers" in the *Wall Street Journal* by Louise Radnofsky, 1/9/13:

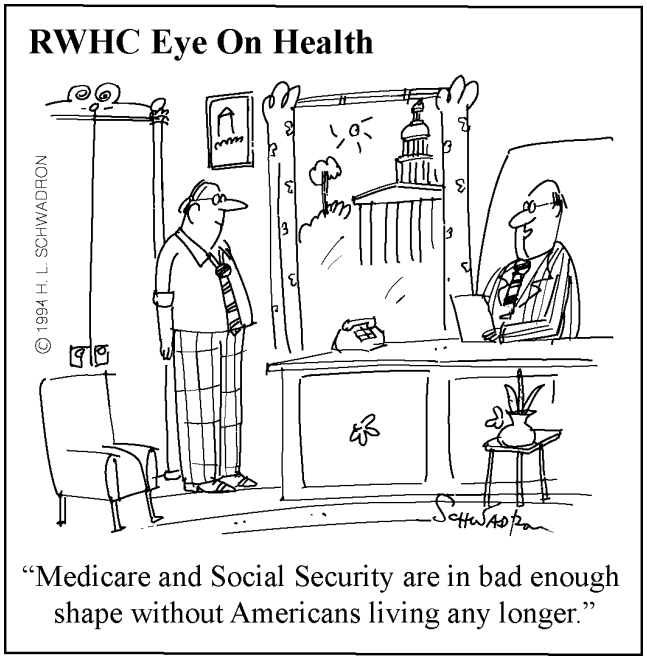
"Americans die younger and have more illnesses and accidents on average than people in other high-income countries—even wealthier, insured, college-educated Americans."

"The study by the federally sponsored National Research Council and Institute of Medicine found the U.S. near the bottom of 17 affluent countries for life expectancy, with high rates of obesity and diabetes, heart disease, chronic lung disease and arthritis, as well as infant mortality, injuries, homicides, teen pregnancy, drug deaths and sexually transmitted diseases."

" '**The [U.S.] health disadvantage is pervasive**—it affects all age groups up to age 75 and is observed for multiple diseases, biological and behavioral risk factors, and injuries,' said the report's authors, who are public-health and medicine academics recruited by the government panels."

"The shorter life expectancy for Americans largely was attributed to high mortality for men under age 50, from car crashes, accidents and violence. But the report also said U.S. women's gains in life expectancy had been lagging behind other well-off countries."

"The authors offered a range of possible explanations for Americans' worse health and mortality, including social inequality. They also described criticisms including limited availability of contraception for teenagers, community designs that discourage physical activity such as walking, air pollution and access to firearms, as well as individual behaviors such as high calorie consumption, to suggest that even affluent Americans were worse off compared with their peers in other countries."



"Medicare and Social Security are in bad enough shape without Americans living any longer."

"The U.S. health-care system wasn't spared criticism, with authors describing it as fragmented, lacking sufficient primary-care physicians and posing financial barriers to millions of Americans who lack insurance or are unable to afford out-of-pocket medical costs."

"But the chairman of the panel of authors, Steven Woolf, a family medicine professor at Virginia Commonwealth University, said the report showed that health outcomes were determined 'by much more than health care.' "

" '**Our health as Americans is only partly aided by having a very good health-care system**,' he said. 'Much of our health disadvantage comes from factors outside of the clinical system and outside of what doctors and hospitals can do.' "

"In America everybody is of the opinion that he has no social superiors, since all men are equal, but he does not admit that he has no social inferiors, for the doctrine that all men are equal applies only upwards, not downwards." Bertrand Russell.

"The Obama administration has aimed to improve Americans' health by expanding insurance coverage through the 2010 Affordable Care Act, while Republicans have pushed for giving the private sector a greater role in managing health care through changes to such programs as Medicare."

"Public health has received relatively little attention from lawmakers, despite campaigns by high-profile figures such as first lady Michelle Obama on childhood obesity and New York City Mayor Michael Bloomberg on smoking, gun control and the sale of high-calorie beverages."

" '**The political environment on health is so wrapped up right now around implementation of health reform that we need to have the space to have this larger conversation and for people to understand that having health insurance is necessary but not sufficient to close this gap**,' said Jeff Levi, head of the Trust for America's Health, a public health advocacy group. He wasn't involved in the study."

"**The new report noted that average life expectancy for American men, at 75.6 years, was the lowest** among the 17 countries and almost four years shorter than for Switzerland, the best-performing nation. **American women's average life expectancy, 80.8 years, was second-lowest** among the countries and five years shorter than Japan's, which had the highest expectancy."

"The report's authors were particularly critical of the availability of guns, writing: 'One behavior that probably explains the excess lethality of violence and unintentional injuries in the United States is the widespread possession of firearms and the common practice of storing them [often unlocked] at home.' "

"**The authors noted that Americans who lived past age 75 had higher survival rates compared with similar countries, and Americans overall had better rates of surviving cancer and strokes. They also said the U.S. better controls high blood pressure, cholesterol, smoking rates and use of alcohol than many other nations**."

"The report didn't directly consider U.S. health in the context of spending on care, but noted that America's low outcomes were striking given that U.S. per capita health spending exceeds that of other countries.' "

The report, "U.S. Health in International Perspective: Shorter Lives, Poorer Health" and related materials are available at ***www.iom.edu***.

How Can the US of A Be Disadvantaged?

From a post "How Could the United States Have a 'Health Disadvantage'?" on the blog *Improving Population Health* at **http://ow.ly/gHqul** by David Kindig, MD, PhD on 1/9/13:

"This was the question that I couldn't keep out of my mind while reading the superb new report from the National Research Council and Institute of Medicine titled 'US Health in International Perspective: Shorter Lives, Poorer Health.' "

"Before I get to my title question, let me briefly summarize the ambitious effort that this distinguished panel, chaired by Population Health expert Steve Woolf from Virginia Commonwealth University, has produced for both scholars and policy makers. In the opening summary the authors assert, '*The United States is among the wealthiest nations in the world, but it is far from the healthiest… Americans live shorter lives and experience more injuries and illnesses than people in other high income countries… The US health disadvantage cannot be attributed solely to the adverse health status of racial or ethnic minorities or poor people, since recent studies suggest that even highly advantaged Americans may be in worse health than their counterparts in other countries.*' "

"Concluding that no single factor can fully explain the differences in health outcomes identified in the report, the authors considered the possibility of an unidentified root cause. In a provocative chapter on 'Policy and Social Values' they question the possible role of 'characteristics of life in America that create material

interests in certain behaviors or business models,' and discuss the roles of 'five iconic American beliefs' such as individual freedom, free enterprise, self-reliance, religious values, and Federalism. While the committee acknowledges that no empirical evidence exists to link these factors to the poor performance they document, this chapter should certainly be the basis for much discussion and future research."

The report does have some limitations worth mentioning, including its exclusive focus on aggregate health status of the US and other high income countries. The authors acknowledge that addressing disparities within countries, which can be as great as those between, was beyond the scope of the investigation. This is certainly understandable given the massive effort the report represents. But they also assert that addressing disparities is a 'paramount national priority' that is worthy of equally rigorous study."

"As useful as cross national analysis can be, it is possible for some to dismiss the implications because of fundamental differences in national cultures and policies. This limitation is significantly less when exploring similar differences within national boundaries of even such a large and diverse country as ours."

"So are we disadvantaged? In a footnote the report defines the term health disadvantage as 'a condition of relative inferiority, reflecting the unfavorable health outcomes in the United States compared with those in other high-income countries… the term is not meant to imply that the United States, among the wealthiest countries in the world, is disadvantaged in the dictionary sense of, 'lacking in the basic resources or conditions (as standard housing, medical and educational facilities, and civil rights) believed to be necessary for an equal position in society.' "

"But in reading one of the references in the provocative social value chapter I found this definition of American disadvantage: 'a unique weakness of its social safety nets, the magnitude of social inequalities, and the harshness of its poverty.' Thought of this way, disadvantage is certainly a compelling hypothesis deserving serious and urgent attention of population health scholars and policy makers."

David Kindig is professor emeritus at the University of Wisconsin in the School of Medicine & Public Health and editor of the blog "Improving Population Health."

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the "rural advocate of choice" for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare… assists Members to partner with others to make their communities healthier… generates additional revenue by services to non-Members… actively uses strategic alliances in pursuit of its Vision.

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Why US Health Care Different?

From "How and Why US Health Care Differs From That in Other OECD Countries" by Victor Fuchs, in *Journal of the American Medical Association,* 1/2/13:

"United States health care, often hailed as 'the best health care system in the world,' is also faulted for being too costly, leaving many millions of individuals uninsured, and having avoidable lapses in quality. Criticism often draws on comparisons with other countries of the Organization for Economic Co-operation and Development (OECD). This Viewpoint also makes such comparisons, over a broad range of variables, and reaches one inescapable conclusion—US health care is very different from health care in other countries. Potential reasons for the differences are discussed, leading to the conclusion that future efforts to control cost, provide universal coverage, and improve health outcomes will have to consider the United States' particular history, values, and political system."

Us Vs OECD: Health Expenditures And Outcomes–"Compared with the average OECD country, US health care expenditures differ in 3 important

ways. First, as a percentage of gross domestic product, US expenditures are twice as high. Second, the US share of health expenditures funded by government is much lower, 46% vs 75%. Third, the mix of services provided (technology intense vs more basic care) is very different."

"The larger role of government in health in OECD countries and the difference in mix of services are the main proximate explanations for the higher level of spending in the United States. Because funding in most OECD countries is usually through a tax-supported system, administrative costs are usually much lower than in the United States, with its fragmented sources of funding and payment. Also, the OECD countries use the concentration of funding to negotiate aggressively with drug companies and physicians and to control investment in hospitals and equipment."

"The United States could use Medicare's buying power in a similar way, but legislation and political pressure prevent such an approach. The OECD countries provide more physicians and more acute care hospital beds, whereas the United States provides much more high-tech services, such as magnetic resonance imaging (MRI) scans and mammograms, proportionately more specialists, more amenities (privacy and space in hospitals), and more standby capacity as evident in a higher ratio of MRI scanners available to MRI scans performed. The greater number of physician visits and hospital days in OECD countries does not result in higher spending because of differences in services provided during a visit or a hospital day. In general, the United States has an expensive mix, whereas the OECD countries have an inexpensive one."

"The effect of these differences in mix and total expenditures on health outcomes is uncertain. Measured by life expectancy, the OECD countries do slightly better than the United States, but firm conclusions are elusive because life expectancy depends on many factors in addition to medical care. For instance, the percentage of population in poverty is much higher in the United States than in the OECD countries (17% vs 9%), and poverty is a predictor of early death. Health is probably distributed less equally in the United States than in the OECD countries because the United States has more individuals without insurance and greater income inequality."

Why The Differences?–"Three basic differences between the United States and most other OECD countries might explain why health policy differs. First, US individuals appear more distrustful of government, a distrust that has deep historical roots. It was an armed rebellion against the government of King George III that led to the founding of the United States. It was Thomas Jefferson, a principal founding father, who said, 'That government is best which governs least.' The initial antigovernment sentiment has received recurrent 'booster shots' from waves of immigrants who came to the United States seeking freedom. Their willingness to risk life in a new land was frequently fueled by negative experience with government in their home country, a government that oppressed them because of their political beliefs, religion, ethnicity, or social class. Medicare and Medicaid appear to be an exception to distrust of government, but these programs provide insurance for populations that were not and could not be served by private insurance. A Pew public opinion survey of a representative sample of US individuals about their atti-

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Coverys: Coverys has provided medical professional liability insurance to healthcare communities for over three decades. You can learn more by visiting **www.coverys.com** Matt Wahoske, Managing Director for Wisconsin, can be reached at 608-469-8590 or **mwahoske@coverys.com**.

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tude toward elected officials showed more than twice as many negative as positive views."

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"Closely related to the weaker support for government action in the United States is a reluctance to achieve more equal outcomes for the population through redistributive public policy. Although US individuals have always rejected European-style class distinctions that required deference and subservience, the declaration that 'all men are created equal' did not carry any suggestion of equality of outcomes, such as in income or health. The income tax is less progressive in the United States than in most OECD countries, and the redistributive effect is augmented in the OECD countries by more egalitarian transfers of money and services. In response to a Pew survey, 4 of 5 US individuals agreed that 'everyone has it in their own power to succeed.' Only 1 in 5 agreed that 'success in life is pretty much determined by forces outside our control.' Whether this view reflects reality is another matter. It is attitude and beliefs that shape voting behavior."

"Heterogeneity of the US population tends to strengthen resistance to redistribution. Diversity of race, religion, ethnic origin, and sometimes language contribute to a weaker sense of empathy for less fortunate members of society, whose identity may differ greatly from one's own. In more homogeneous nations, such empathy is more likely to be experienced and acted upon. Weak support for redistribution at the national level in the United States stands in sharp contrast with redistribution within self-defined more homogeneous groups (for example, Mormon Relief Societies, Jewish homes for the aged in almost every major city, and the founding of Baptist, Catholic, Lutheran, Methodist, and other sectarian hospitals)."

"The third, and probably most important, difference between the United States and most OECD countries is the political system. Many observers attribute US failure to enact comprehensive health care reform to the opposition of 'special interests,' such as pharmaceutical and device manufacturers, insurance companies, physicians (especially those in high-income specialties), and hospitals. But all countries have special interests; only in the United States have they been particularly successful in blocking comprehensive reform. This success can be explained in part by noting that the US political system is different from the parliamentary systems of most OECD countries in ways that make special interests more effective."

"Some of these differences are built into the US Constitution, including the checks and balances provided by 2 separate houses of Congress with their powerful committees, plus an independent executive branch with veto power. Some differences have evolved over time, such as expensive primary election battles, long election campaigns, and the Senate filibuster. Thus, the US system provides many 'choke points' for special interests to block or reshape legislation. Also, in recent years, contributions from special interest groups significantly influence who runs for office, who gets elected, and how elected officials vote."

"The Matrix" Meets Medicine

From " 'The Matrix' Meets Medicine: Surveillance Swoops Into Health Care" by Michael Millenson in *Kaiser Health News*, 1/9/13:

"In a control room at the Sioux Falls, S.D., headquarters of the Evangelical Lutheran Good Samaritan Society, nurses keep round-the-clock watch on motion and humidity sensors in the living rooms, bedrooms and bathrooms of elderly men and women in five states."

"The seniors–a handful in their own homes and the rest in assisted living facilities owned by Good Samaritan–are part of one of the most comprehensive remote health monitoring efforts anywhere. Using sophisticated sensors, computerized pattern recognition and human responders, Good Samaritan hopes to show it can detect and head off health threats to the elderly and thereby accomplish two important goals. The first is saving money on medical costs. The second is helping seniors feel secure enough to 'age in place' at home or avoid moving from assisted living to a skilled nursing facility."

"Whether this costly technology will ultimately prove clinically or economically effective remains uncertain. So, too, is whether a benign health care purpose can help overcome the unsettling 'Big Brother' overtones for some potential users. What is clear, however, is that health care is joining a national trend toward greater surveillance of everyday life."

"For example, more than 70 U.S. cities now use ShotSpotter sensors to pick up the sound of gunfire and alert authorities even before 9-1-1 is dialed. Auto insurers are hooking up sensors to a car's computer system to monitor driving habits and, with the driver's permission, calculate premiums accordingly. Even some farmers are equipping cow collars with monitors allowing automated milking systems to track the cow's milk production, amount of feed eaten and even how long it chews its cud. If the system detects a problem, it can call the farmer on his phone."

"What benefits bovines might also help humans, albeit with appropriate modifications. With an $8.1 million grant from the Leona M. and Harry B. Helmsley Charitable Trust, the LivingWell@Home study began collecting data at 40 of its assisted living facilities in 2011, and will stop at the end of June 2013."

"LivingWell@Home comprises three technologies. First, sensors from WellAware Systems are distributed throughout the living space. (The company stresses that no cameras or microphones are involved.) When a senior is sleeping a motion sensor records how often he or she moves in bed. Showering, toileting and other activities of daily living are also analyzed by WellAware algorithms and scrutinized by nurses for changes that might signal health problems."

"The second piece is a medical alert button from Philips Lifeline that includes an auto-alert function designed to detect a fall and call for help even if the user is incapacitated. Lastly, remote monitoring is provided by the telehealth unit of Honeywell through a clock radio-sized console in each apartment. It turns on each morning and prompts seniors to strap on a special blood pressure cuff, step on a special scale and transmit that and other information back to the monitors in Sioux Falls."

"Jacci Nickell, who is Good Samaritan's vice president of development and operation delivery systems, emphasizes that the technology is just a tool. 'Unless you gather, integrate and interpret that data in a meaningful way to the client and to their formal and informal caregivers, a sensor hanging on a wall isn't going to help anyone,' she says. 'It's what you do with that data, and how you optimize wellbeing.' "

"Good Samaritan isn't waiting for the study results to be finalized to roll out the LivingWell@Home service, in which the system has a financial stake, as an option in all its assisted living facilities. It's also putting parts of the technology into some skilled nursing facilities and even into seniors' own homes."

"The organization's website tells the story of an elderly woman who agreed to have the sensors installed in the South Dakota farmhouse where she lived alone. Not long afterwards, the sensors detected a change in her toileting that prompted a call from a nurse. In response, the woman sought out her doctor, who discovered a bladder infection."

" 'We think the use of the technology can reduce the need for physical visits and will save expense and time,' Nickell says. Still, the high-tech security blanket doesn't come cheap. The technology costs $500 to $750 per month per person at home and about $175 a month for residents in Good Samaritan assisted living facilities that already have a personal emergency response button service. By comparison, notes Mary Cain, managing director of

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"It works like an electronic dog fence;
you try to walk into a fast food restaurant
and you get the 'bejesus' shocked out of you."

consulting firm HC3, conventional disease management costs well under $100 per month per patient."

" 'It's a very small percent of the population that's going to benefit from [the Good Samaritan] level of monitoring,' Cain says. 'How many will you monitor, and who is paying?' A similar cautionary note comes from a spokeswoman for United Healthcare, the nation's largest health plan. United already covers devices such as those used to detect abnormal heart rhythms or measure blood sugar. But 'health insurers typically rely on guidance from the clinical community in making coverage decisions,' says the spokeswoman, and with sensors and similar technology 'it's too early to do so at this time.' "

"Privacy also remains a concern. Some critics may detect overtones of a 1983 song by The Police that warns, 'Every breath you take, every move you make, we'll be watching you.' As Christine Sublett, a health privacy and security consultant, put it: 'Individuals should have the right to know exactly what information is being transmitted and that appropriate controls are in place.' Good Samaritan says it takes appropriate precautions, but the research study may not provide a rigorous test of protection against hackers. Nor has Good Samaritan or its vendors yet encountered patients demanding their own data feed, as has happened to makers of defibrillator monitors and similar technologies."

"Still, other companies are jumping into this market. For instance, StealthHealth offers a radar beam to provide in-home monitoring of vital signs, activities of daily living and falls. The company suggests its equipment be placed inconspicuously behind a picture frame. And GrandCare Systems offers to collect data from motion, temperature, door, chair and bed sensors, in addition to pill box sensors for monitoring medication use and caller ID information to keep an eye out for telephone scams."

Support NRHA's New Rural Health Foundation

The National Rural Health Association has launched a permanent endowment **for programs that identify emerging leaders from and for rural communities.** The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

*Go to **http://ow.ly/ejmLf** to learn more.*

Rural Think Tank Scores Major Support

From "Invaluable rural health policy analysis" by Bill Barker in *IowaNow*, 1/9/13:

"The Leona M. and Harry B. Helmsley Charitable Trust has provided the Rural Policy Research Institute (RUPRI) Health Panel with a three-year, $600,000 award to continue its work providing science-based, objective policy analysis to federal and state health policy makers in the area of rural health. 'This award ensures that the panel will continue to be actively engaged in rural health policy dialogue on a national level,' says Keith Mueller, chair of the panel and head of the Department of Health Management and Policy in the University of Iowa College of Public Health. In the midst of this dramatic transformation that's taking place in rural health care delivery and finance, stakeholders will need RUPRI's unbiased, evidence-based analysis of rural implications of the choices they face."

"Mueller refers to the comprehensive approach to reform embedded in the Patient Protection and Affordable Care Act (ACA) as a policy area for which the panel's advice will be crucial. 'Regardless of the outcomes of challenges to the ACA, major changes in health care delivery and finance already underway will not be reversed, and the panel must be ready to provide policy documents, briefings, and consultations on specific policy decisions to ensure the health of our rural population is well protected,' says Mueller."

The Workforce "Lull Before the Storm"

From "Advanced Practice Professionals on the Rise at Wisconsin Hospitals" by Tim Strum in *Wisconsin Health News*, on 1/10/13:

"Wisconsin hospitals are hiring more nurse practitioners and physician assistants. That's according to a new workforce report from the Wisconsin Hospital Association at **http://ow.ly/gJym4** From 2009 to 2011, state hospitals reported a 55 percent increase in the number of advanced practice nurses they employ, a

38 percent increase in nurse anesthetists, and a 25 percent increase in physician assistants."

" 'The aging of Wisconsin's population, combined with a growing primary care physician shortage, has created new opportunities for advanced practice health care professionals to apply their expertise in the hospital setting,' said the association's vice president for workforce development Judy Warmuth. 'Eleven years ago when WHA conducted its first hospital workforce survey, the number of these professionals directly employed by hospitals was not significant. Today, we've seen a significant jump, and we are confident we will continue to see this trend.' "

" 'Advanced practice nurses and physician assistants are a critical component of the patient care provided by Tomah Memorial,' said Tomah Memorial Hospital CEO Phil Stuart. 'These professionals improve access to care, increase the speed with which we can offer care, and help us assure that the care our hospital provides is efficient and effective for our patients. Meanwhile, positions such as pharmacists and radiology technologists–jobs that four years ago hospitals struggled to fill–are now at historically low vacancy rates. Still, more than 36 percent of medical technologists are older than 55 years and their impending retirements will create new, difficult-to-fill vacancies, according to the report."

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"Okay Doc, very cute, but you can get back to work now."

"**Increased workforce data collection will be key, said the hospital association**. 'We must act now, in times when we are not facing critical workforce shortages, to assure that we can compete with other states to attract a workforce that can help us meet the growing demand for medical services in Wisconsin,' Warmuth said."

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