

Review & Commentary on Health Policy Issues from a Rural Perspective - September 1st, 2001

Medicare Future Hung Up On Political Fence

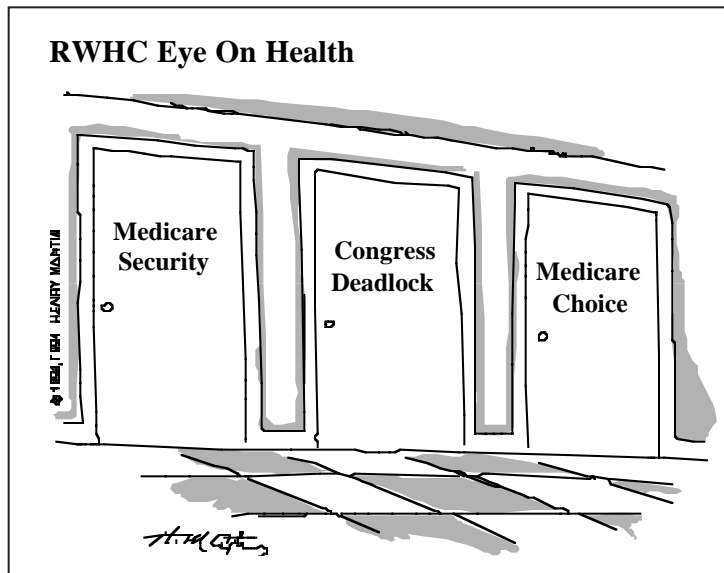
From “The Conflict Over Drug Benefits” by Robin Toner, *The New York Times*, 8/5/01:

“Medicare, like so much else in the nation’s social policy, seems caught between two worlds: the glory days of the Great Society, when triumphant liberals considered Medicare the first step toward a system of universal government health insurance; and the hey-day of Ronald Reagan and the Gingrich revolution, when triumphant conservatives dreamed of replacing the bureaucracy of many government programs with vouchers for use in a vibrant private marketplace. This conflict over the role of government shapes much of the domestic agenda, from the debate over adding private investment accounts to Social Security to the struggle over creating vouchers so families can opt out of the public school system.”

“ ‘Security’ is the rallying cry for one side, which argues that government programs were put in place to address the failures of the private sector — Franklin D. Roosevelt and his New Deal are the touchstones — and that Americans can do things as a group that they cannot do alone. ‘Choice’ is the rallying cry for the other side, which argues that individuals, given the opportunity, can make better decisions for themselves than any government bureaucrat could.”

“For all the attempts to blur distinctions and appeal to the center, from ‘compassionate conservatism’ to ‘the third way,’ this conflict has proved as sharp as a razor’s edge in an evenly divided government. Nowhere is it more apparent than Medicare, the sturdy social insurance program pushed through Congress by President Lyndon B. Johnson. ‘There’s an ideological stalemate similar to what preceded the creation of Medicare,’ said Theodore R. Marmor, author of ‘The Politics of Medicare.’ ‘We are tied in knots in Congress about the role of government.’”

“For this is about two different worldviews. Traditional Democrats argue that the vaunted health insurance marketplace has never met the needs of the elderly — not before the creation of Medicare, when half had no health insurance; and not in the current, limited experiment with H.M.O.’s in Medicare, which has seen numerous pullouts by private health plans complaining that they could not make a profit.”



“Medicare works, the traditionalists argue, because everyone contributes, everyone shares the risk, and everyone gets the same benefits — with government administering the program and regulating payment levels.”

“The surest sign of its success, they argue, is its popularity, particularly in comparison to the world of managed care. ‘If you go up to the average citizen

and say, we’ve got a great idea, we’re going to help you, we’re going to take Medicare and replace it with H.M.O.’s, people would think you were nuts,’ said

“Those that are good manners at the court are as ridiculous in the country as the behavior of the country is most mockable at the court. You told me you salute not at the court, but you kiss your hands; that courtesy would be uncleanly if courtiers were shepherds.” Shepherd Corin to the fool Touchstone, *As You Like It*, Act Three, Scene 2.

Bruce C. Vladeck, the head of Medicare in the first Clinton administration.”

“Conservatives who advocate a more privatized Medicare argue that a system of one-size-fits-all benefits, which can essentially be changed only by Congress, with rigid regulations imposed by the federal government, is outmoded. In President Bush’s vision, the elderly will get a fixed amount of money to be spent in a marketplace of private plans competing for their business. And while older Americans could choose to stay with traditional Medicare, market advocates have no doubt about where they will want to go.”

“ ‘The plans will compete with each other, forcing them to offer better service, extra benefits and lower premiums,’ Mr. Bush has said. ‘We must trust seniors to make the right decisions for themselves.’ Conservatives also argue that the Medicare program, a last bastion of fee-for-service medicine, must become more cost-efficient before the onslaught of the baby boom retirees about a decade from now; more competition, they argue, will force that efficiency.”

“Much of this debate, on Medicare, Social Security and other issues, is driven by almost religious convictions – like the belief that individuals will make wiser decisions about their retirement money than government. This debate, inevitably, is shaped by the times. The pro-market, pro-competition theology gained strength during the extraordinary economic expansion of the 1990’s. Now, in a time of economic uncertainty, after a historically close election, the two camps seem far more balanced.”

“Robert J. Blendon, a professor of health policy at the Harvard School of Public Health, said the public is closely divided on whether government is doing too much or too little. But on Medicare, it’s not a close call, particularly among the elderly.”

“Bill McInturff, who advises Republicans, said he tells his clients: ‘Seniors love the current Medicare program. This is not the time to relitigate the role of the federal government.’ Geoffrey Garin, a Democratic pollster, explained: ‘As you move down in the generations, there is probably a greater attraction to the idea of individual empowerment. But a lot of these debates, at the end of the day, are not about government versus individuals. They’re about government versus big business.’ ”

“That, at least, is how the Democrats like to frame it; their enemy is rapacious drug companies and health insurers; the Republican demonology revolves around big government bureaucrats...”

“The positive case for social insurance is heard less often, says Theda Skocpol, a professor of government and sociology at Harvard. ‘There’s an ambivalence that probably runs through both parties and runs through the minds of many Americans,’ she says, ‘because there haven’t been frank statements in our political discourse about the value of sharing resources and sharing risks for a long time.’ ”

“A conservative counterpoint comes from Stuart M. Butler, an analyst at the Heritage Foundation: ‘If you looked at it from outside, you’d say it clearly wouldn’t work, and lo and behold, it doesn’t.’ In the debate over Medicare, and later over Social Security, these world-views will collide. Many analysts suggest that this deadlock can only be broken the way it was broken in the past—one side wins, big, on Election Day, and gets a chance to try and legislate its vision.”

Losing The Ethic Of Caring For Your Neighbor?

From “Charity Lost In Social Security Debate” by Avrum Lank, business and financial columnist, in the *Milwaukee Journal Sentinel*, 8/12/01:

“An important consideration has been largely ignored during the debate over the future of Social Security: The program redistributes income. While people paying the highest Social Security taxes generally do not get benefits equal to their contributions, lower-paid workers generally take out more than they put in.”

The Rural Wisconsin Health Cooperative, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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“This intended consequence of the system is a jewel of American political culture. It has kept millions of working-class Americans out of poverty during their retirement.”

“But the jewel may shine less brightly in the future, reflecting a basic change in the nation's ethics: Americans are moving away from a belief in mutual responsibility for each other's welfare. The income-redistribution aspect of Social Security would be undermined by the plan favored by President Bush to let Americans privately invest about 13% of their Social Security taxes.”

“Yes, 13%. The president talks about letting people put 2 percentage points of their Social Security taxes into private accounts, but that would be about 13% of the dollars now paid into the system.”

“Unless those dollars were made up collectively from general tax revenue or borrowing, benefits would have to be cut. If the benefit cuts were equal across all Social Security beneficiaries, poorer recipients would suffer the most.”

“That the plight of the working poor is getting short shrift in the national discussion of Social Security reform is a symptom of our nation's increasing loss of a sense of shared responsibility and destiny.”

“Rugged individualism is a touchstone of American mythology, but the truth is that our greatest accomplishments have been the result of mutual effort.”

“The government supported pioneers clearing the wilderness and provided lavish subsidies to their farmer descendants. Wars were fought by all members of society, industrial might created by legions of workers, and benefits won for those workers through the efforts of unions.”

“Yet somehow, when it comes to the most fundamental of human needs, American political culture in the 21st century has turned away from mutual responsibility.”

“It is not just in the Social Security debate that this is obvious. Americans also do not want to take mutual responsibility for health insurance.”

“Rather than working toward a rational system of shared responsibility to make sure that Americans do not face bankruptcy because of a chance encounter with a disease, our health care system encourages a free-for-all where helping the unfortunate is profitless.”

“Rather than charge all Americans the same premium for health insurance, our system requires the sick to pay more than the healthy.”

“But just as poorer people have less to invest, so the ill have less to pay for health insurance. As a result, fewer sick people are insured.”

“The answer is setting up a system where responsibility is spread as widely as possible, with everyone paying the same health insurance premium, no matter their age or vigor.”

“But that would require some people to subsidize the benefits of others, and as we are seeing in the debate over Social Security reform, many of America's leaders no longer feel they can support such a charitable notion.”

Changing Health Plan, Physician Relationships

From “Reevaluation Of Capitation Contracting In New York And California” by James C. Robinson and Lawrence P. Casalino, *Health Affairs Web Exclusive*, 5/17/01:

“We obtained detailed quantitative and interview data from Aetna U.S. Healthcare and six physician organizations to examine changes between 1998 and 2000 in the scope of capitation contracting and delegation or responsibility for claims payment and medical management in New York and California. In both California, where global and shared risk capitation have been common, and New York, where they have not, we find movement to reduce the scope of prepayment and a rethinking of the delegated contractual relationship by physician organizations and health plans. This represents a departure from the 1990s, when many industry participants and analysts expected capitated and delegated relationships to spread across the nation.”

“Contractual relationships between health insurance plans and physician organizations are under severe strain. Many medical groups, independent practice associations (IPAs), and physician-hospital organizations (PHOs) were created and expanded during the 1990s in anticipation of a transfer of financial and clinical responsibilities from insurers to providers. However, lower payment rates from Medicare and private insurers have undermined the attraction of global capitation to provider organizations, while increased regulation and liability have heightened wor-

ries within health plans concerning the delegation to providers of medical management and claims payment.”

“In California, where medical groups and IPAs are common, the basic contractual structure of capitation and delegation remains in place, but the scope of services subject to capitation is being reduced and health plans’ monitoring of claims processing and medical management is being intensified. In New York, where large medical groups and IPAs are uncommon, health plans are retaining responsibility for network development, provider payment, claims processing, and medical management and are reconsidering their willingness to contract with physician organizations at all. The reevaluation of plan-physician contracts is being conducted in a charged atmosphere of distrust.”

“The health care system is passing through a period of turmoil and transformation. Increased oversight by health plans and governmental agencies may weed out weaker physician organizations and stabilize the finances and medical management systems of those that remain, thereby leading to a revival of the medical group role in managed care. Alternatively, the changing environment may prove inimical to large physician organization and foster a return to solo and small-group practice, paid on a discounted FFS basis and monitored by outside entities, as the dominant organizational structure for medical care delivery.”

So, Why Choose To Be A Rural Doctor?

This is from “So, Why Choose To Be A Rural Doctor?” by Dr. Jim Rourke, as posted on the Canadian based list serve, <RURALMED@LISTS.MCGILL.CA>. This is a good source of information on the status of Canadian rural medicine and practitioners, equally if not more stressed than rural health in the United States. It was written as a response to “Why I Will Refuse To Be A Rural Doctor” by James Worrall, (*Globe and Mail*, Facts & Arguments, 7/24/01):

“ ‘Remember the days of the young family doctor and his adoring wife setting up house in the country, so he can build a practice and she can raise the kids? Those days are gone.’ James Worrall is right. The heyday of the solo rural family doctor came to an end in the previous century. Even so, as Dr. Worrall says: ‘Rural medicine is a hot topic, at the moment, because of physician shortages in rural areas across the country.’ ”

“Right now, Canadian medical schools, federal and provincial governments and countless rural and regional communities are trying very hard to interest medical students and residents in the joys of a career in rural medicine. However, as Dr. Worrall points out, although quite a number are interested, the truth is that most of them will ultimately stay in the city.”

“If we are going to be successful in educating and recruiting rural doctors who will provide quality health care where needed throughout Canada, we need to listen carefully to the concerns of medical students and residents as expressed by James Worrall. Certainly, the life of a rural family doctor is not for everyone.”

“Practicing and living as a family doctor in a small town is full of joys and challenges, most often both sides of the same coin—the joy of knowing your patients well, the challenge of knowing your neighbor as your patient; the joy of delivering babies, the challenge of managing serious emergencies with little local specialist backup; the joy of living in the country, the challenge of finding time to enjoy it; the joy of raising children in a safe, quiet small town, the challenge of finding educational opportunities to develop each child’s potential; the joy of working close enough to home to have lunch with your children, the challenge of limiting family disruption from on-call.”

“Recruitment and retention of rural physicians is complex. Some professional and personal factors - such as job opportunities for spouses - are important but difficult to modify. In contrast, working conditions, practice support, and compensation, are modifiable. It is time to fully implement a comprehensive strategy



that includes the following:

1. Build a supportive rural health infrastructure that includes more group practice clinics in small communities to provide excellent working conditions with a shared on-call and work schedule to enable time off and time away.
2. Provide attractive incentives and rewards for doctors who choose rural practice; the smallest and most remote communities, of course, will need to offer the largest incentives.
3. Graduate more students with both the knowledge and interest in rural practice by:
 - a. ensuring that more students from rural background can get into medical school
 - b. ensuring that medical students get early and repeated rural learning experiences to encourage those from all backgrounds with a possible interest in rural practice and increase understanding of rural health care by the rest (as many rural people will need to get some care from urban specialists)
 - c. increasing the number of rural family medicine training stream positions to train more family doctors for rural practice.”

“As I said before, the joys and challenges of rural medical practice are not for everyone, and we need doctors in the cities, too. However, it is now imperative that we concentrate on implementing improved rural medical education, as well as offering attractive recruitment and substantial support initiatives to attract and support those doctors who provide health care for the rural people of Canada.”

“But what about James Worrall’s statements that city life is full of fun, and convenience and possibility? I can’t argue with that. As a family doctor in a small resort town on Lake Huron, I have to admit that a holiday for my family is sometimes a trip to a big city. But it’s always so nice to come home again to small town life and rewarding practice.”

Dr. James Rourke has been a rural Family Doctor in Goderich, Ontario for the past 22 years. He is also a Professor in the Department of Family Medicine at The University of Western Ontario.

Public Thanks, Whether Fred Wants It Or Not

A tribute to Fred Moskol, recently “retired” Director of the Wisconsin Office of Rural Health, introduced by Tim Size with notes from Wisconsin colleagues:

While Fred Moskol has not been working for Wisconsin, for rural health and for people needing a better health care system since Wisconsin became a State, it sure seems like it. We are glad that he is not retiring from the field, but the termination of two decades of leadership at the Office of Rural Health is a milestone that deserves significant recognition. When he hears of this effort to publicly acknowledge his contributions in and beyond Wisconsin, he most certainly will blush and let out a flustered “oh jeez,” (his usual involuntary impression of Archie Bunker, albeit a liberal variant.) We make no apology for the personal nature of this tribute--it is intended. Fred is more than a key colleague--he is a friend.

Fred had a life of sorts before rural health, but that is not our focus. From a January email in ‘97 where he is reflecting back on having worked as a pharmacist—“I did indeed fit trusses, garments, colostomies, ileostomies, breast prosthetics and urinals for incontinent males, amongst other things. I actually have a certificate that says I took the training. So if you ever need help...” In this and many ways, Fred was always extraordinarily generous. But at the same time he challenged us to think and work beyond the silos of constituency, geography, profession, class and race.

For me he was a mentor even when I know he took abuse at the University of Wisconsin for some of the Cooperative’s more energetically expressed positions. He introduced me to the national rural health advocacy community, which he has been an integral part, including a stint as President of the National Rural Health Association. He made it clear to all of us that that it was not enough to just stay in Wisconsin if you wanted to make a difference for Wisconsin--he organized and lead endless trips to members of Wisconsin’s Congressional delegation so that each of us could tell our story. He looked for and shared funding and opportunities relevant to a diverse array of communities and organizations.

Fred would be the first to disclaim nomination to sainthood (not the least due to pride in his own heritage). My southern Baptist mother always preached about the need “to be in the world but not of it” and that describes for me as good as anything, Fred’s uneasy role at the University. Maybe Fred could of, should have been less of an institutional maverick, been a

better internal team player but that is hind-sight. All we know “on the outside” is that he made a real difference in many ways to many people and initiatives.

Now from a few other friends and colleagues:

Sarah Lewis (Wisconsin Primary Health Care Association): “Among his many other creative accomplishments, Fred was a founder of the Wisconsin Primary Health Care Association and has been a valued participant in its development and activities over the past twenty years. When I came to the Association three years ago, Fred quickly became my trusted educator, mentor, friend, (and occasional chauffeur by air to various meetings around the state and Midwest).”

“I have been privileged to collaborate with Fred on several innovative projects focused on improving access to primary and mental health care services for rural communities. Fred has assured me that he intends to continue aggressively pursuing our shared mission; he will simply be doing it from a different

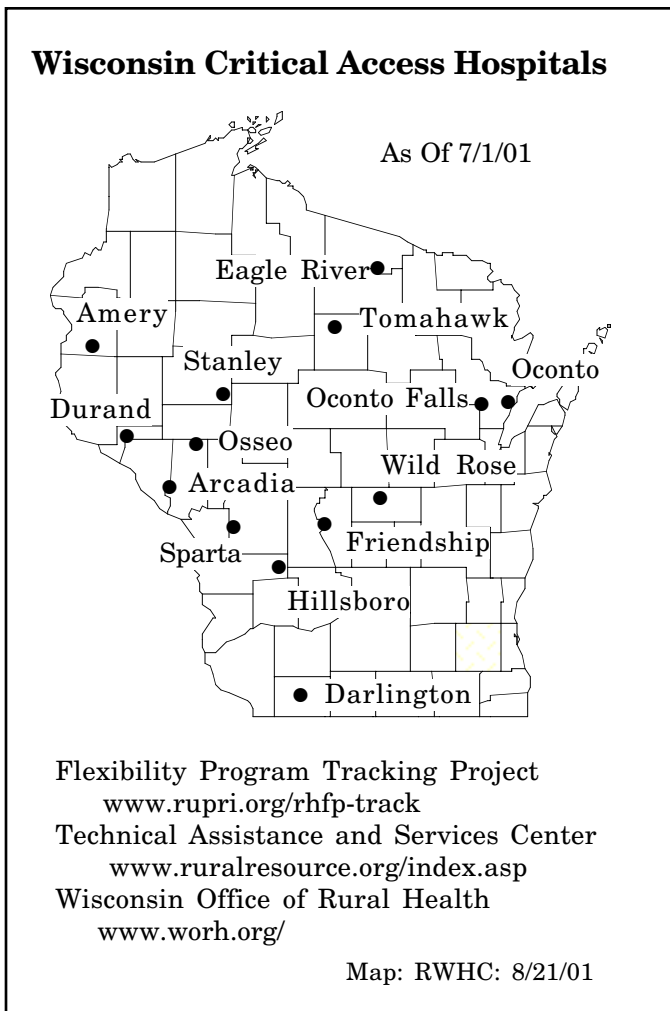
address. I am thrilled that we will have the benefit of Fred’s experience, wisdom, and creativity as we confront the tremendous challenges in providing access to health care to all Wisconsinites.”

Greg Nycz (Marshfield Clinic): “Fred in his leadership role in the Office of Rural Health understood the importance of a connection to the inner city. Some time ago I witnessed an exchange between the then-Chairman Pete Stark and Wisconsin Congressman Steve Gunderson. Congressman Gunderson was testifying to Stark’s committee on behalf of the House’s rural health caucus. At the conclusion of his testimony, Congressman Stark said, ‘I have a large vacant lot in my district, would that qualify me to be a member of the rural caucus?’ The response was ‘Of course, the Chairman would be welcome.’ This illustrates what was second nature to Fred. Concern for health care access problems in the inner city can be central to advancing a rural health agenda. It is what makes Fred a valuable colleague on the Wisconsin Primary Health Care Association board.”

“Baby boomers are old enough to know that Fred was facilitating face-to-face rural-to-urban communication long before telehealth. Whether ‘Fred Aire’ or the ‘WPHCA air force,’ Pilot Fred regularly shortened rural distances for many of us. I recall one trip to the big city-near the waterfront in Chicago, he quipped, ‘If you want to help, help me watch for other planes.’ After spotting six or seven, he’d remark, ‘I’m mostly concerned about the ones coming at us,’ and then you just knew you should have worn your blaze orange.”

“During the ShareCare development phase (later WisconsinCare), we were landing in a grass strip in northern Wisconsin on a cloudy day. ‘Always Helpful Fred,’ with a map spread out on his lap, would note we have to watch out for these towers, and as you slipped in and out of the clouds, he’d remark, ‘It’s down there somewhere,’ illustrating another one of his endearing qualities (always! trying to get people involved). Many of us are betting thanks will continue to be in order for some time to come.”

Roberta Riportella-Muller (University of Wisconsin Extension): “On the drive up to my first Office of Rural Health forum which was held in Wausau, I had the privilege of accompanying Fred. I hadn’t understood the significance of carpooling with Fred at the time we made the arrangements but it quickly became clear that I had made one of the wiser decisions of my professional life. How else would I have started my journey of discovering what rural health means in the State of Wisconsin?”



“Wild Rose was the first community I heard about but it was just one of many that Fred shared with me on that road trip and in many other venues. And it wasn’t just the details of how these communities had struggled with finding health care providers that fascinated me, it was Fred’s passion and devotion that moved me and shaped my own advocacy for rural health issues, a passion about paving the way so that a decent level of health care could be brought to all Wisconsin communities. For this awakening, I am forever indebted to Fred Moskol.”

Jane Thomas (Rural Health Development Council):

“Fred was one of the first people I met as I came on to my unusual position at the, then named, Department of Development. He handed me a button that said ‘I’m for rural health’ and that started my rural health career. Although I had spent many years in the health field, I knew relatively little about the special needs of rural communities. Fred became my mentor and we discovered that our views and values were similar in many areas. I soon memorized Fred’s phone number as I called on him for advice and for any historical question or ‘who was who’ in the health care business. No one was more knowledgeable about health care policy and how to actualize it. I could always count on Fred to help visit clinic sites as part of the physician loan assistance program.”

“I am so pleased that Fred will still be a part of the rural health scene, but I will miss terribly being able to

call on him almost daily as a part of my work. He could always make me laugh, mostly through his self-deprecating humor. He is, indeed, my friend and I will say to Fred that it is so true that ‘when one door closes, another one opens.’ So, Fred, enjoy the vistas through the new door and don’t forget to give us your new phone number!”

The Job Of Leadership: Inspire Commitment

From “Leaders Who Inspire” by Gloria Shur Bilchik, in the *Health Forum Journal*, 4/01:

“As a leader, how do you move from merely motivating the troops to igniting an emotional commitment that yields extraordinary results? In his book *Peak Performance: Aligning the Hearts and Minds of Your Employees* (Harvard Business School Press, 2000), Jon R. Katzenbach suggests that leaders emphasize one or more of the following paths:”

“Mission, values, and pride: Call attention to history and legacy, the organization’s noble purpose and its values. Remind people of accomplishments in support of the mission and focus on how their work contributes to making the values real. Celebrate heroes.”

“Process and metrics: Praise individuals and teams for specific accomplishments, outcomes they’ve contributed to, targets they’ve beaten. Involve workers in establishing outcome goals that mean something to them. Make the numbers meaningful by showing how they contribute to the overall enterprise. Reward employees for achieving their personal best.”

“Individual achievement: Enable employees to do their best work by giving them latitude and “solution space.” Encourage individual initiative and creative outreach. Equip workers with the knowledge and skills they need for personal growth. Offer incentives and rewards for personal achievements.”

“Entrepreneurial spirit: Allow people to take chances. Reward them directly in proportion to what they create and the personal risk they incur.”

“Recognition and celebration: Recognize, reward, and celebrate employees in multiple ways and at all levels for their collective and individual contributions. Through celebrations, create an atmosphere of friendliness, enthusiasm, excitement, energy, and fun. Make celebration and fun an integral part of work life.”

Mark Your Calendar

Wisconsin Farm Health Summit

November 2, 2001, Madison

Hosted by Three Wisconsin Secretaries
Commerce, Health and Agriculture

Discussion Topics Include:

- **Farm Health Care as a Social Justice Issue:**
The Role of Faith-based Organizations
- **Sowing the Seeds of Hope:** The Farm Crisis, It’s Ripple Effects, and a Model for Responding
- **Farm Family Health Care Needs:**
A View from the Trenches

For information contact:
jmthomas@commerce.state.wi.us

At Least Some Tobacco \$ Fights Tobacco Use

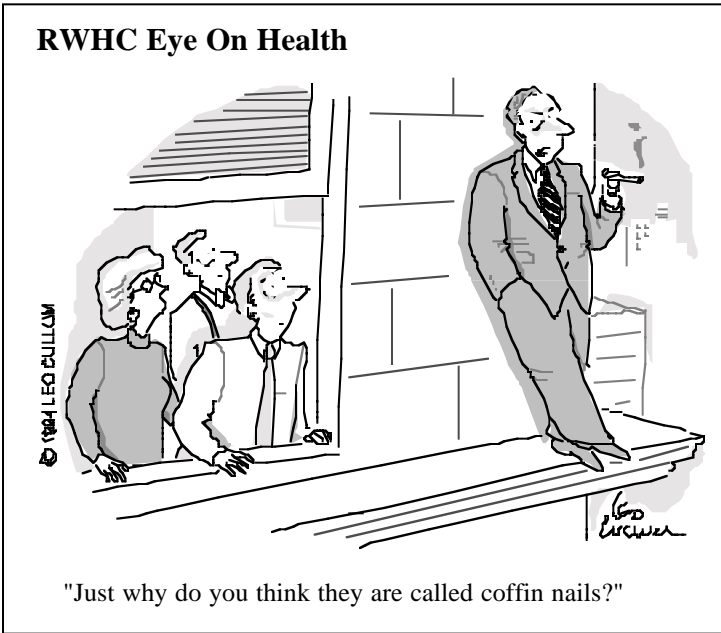
The Wisconsin Tobacco Control Board was established by the Wisconsin Legislature in 1999 to fund state and local programs that prevent and eliminate

tobacco use. For a detailed description of these efforts, the Board's annual report is available on our web site at <www.wtcb.state.wi.us>.

As part of its comprehensive plan, the Board funded the Wisconsin Quit Line. The Quit Line is a telephone counseling service that provides support and motivation. The toll-free Quit Line (1-877-270-STOP) received 5,000 calls in its first month of operation—far exceeding expectations and illustrating the demand and need for cessation support. For more information, call the Quit Line or visit the Center for Tobacco Research and Intervention web site at <www.ctri.wisc.edu>.

In addition, the Tobacco Control Resource Center of Wisconsin (TCRCW) offers a complete source for Wisconsin tobacco information, including how you can get involved with your local anti-tobacco coalition. The TCRCW web site (www.tobwis.org) offers weekly updates with issues and news relevant to the citizens interested in tobacco prevention and cessation efforts. If you are interested in receiving these updates via the listserve, contact Emi Narita at <enarita@facstaff.wisc.edu>.

For more information, contact David Gundersen at 608-267-0944.



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