Is the Window for Health Reform Still Open?
USDA Rural Development State Meeting

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Connecting resources and knowledge to strengthen the health of people in rural communities.

Center for Rural Health

- Established in 1980, at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, ND
- One of the country’s most experienced state rural health offices
- Focus on:
  - Education, Training, & Resource Awareness
  - Community Development & Technical Assistance
  - Native American Health
  - Rural Health Workforce
  - Rural Health Research
  - Rural Health Policy
  - Program Evaluation
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Web site: http://medicine.nodak.edu/crh
Primary Questions

• Why is community important to rural health?

• What are some of the important rural health issues?

• So what is all this talk about health reform?

So Why Is Community Important to Rural Health?

• Rural culture – more interdependence, connectedness, cohesiveness, collaborative, and people identify with institutions and each other

• Relationships – things get done because of people, and sometimes don’t get done because of people – are the right people at the table?

• Rural health contributes to the community – provision of health services (access), improvement of health, economic contributions, community development, health facilities are a sense of community identity

• Communities contribute to the rural health system – employees, purchase of health services, financing, fund raising, volunteers, ideas and vision
A Guiding Principal for Rural Health

“Vision is the art of seeing things invisible”

Jonathan Swift

What are Some Important Rural Health Issues?

• Access to and availability of care
• Financial concerns facing rural hospitals and health systems
• Health workforce
• Quality of Care
• Health Information Technology
• Networks – rural hospitals, urban hospitals, clinics, others
• Emergency Medical Services – EMS, ambulance, quick response units
• Community and Economic Development
• Health System Reform
CAH Conversions
North Dakota Hospitals and Critical Access Hospitals

North Dakota Primary Care Health Professional Shortage Areas

Primary Care Health Professional Shortage Areas
- D = Designated Geographically Disproportionate Area
- DPA = Designated Population Primary Care Area
- R = Residency
- NPA = National Primary Care Area
- H = Hub
- CAH = Critical Access Hospital
- Flex Program
Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality (measured by AHRQ)

NORTH DAKOTA - 2009

Performance Meter: All Measures

= Most Recent Data Year

= Baseline Year

(Baseline year may vary across measures)
Health Care and Economic Sectors Contribute to Community Development

Health Care Sector
- Health Status
- Services
- Employment
- Finance
- Resources
- Element in the local economy

Economic Development Sector
- Wealth and prosperity
- Product – goods and services
- Employment
- Capital, investment, income
- Resources
- Grow and maintain local economy

Health and Economic Convergence
- Global or macro level goals
- Acquisition and management of resources
- Employment – primary and secondary jobs
- Finance – inflow and outflow
- Economic impact
- Overall community building
  (Source: Brad Gibbens, Center for Rural Health, 2009)

Why the Need for Health Reform?

- U.S. health system – equity issues
- Spend the most but do not have the best health outcomes
- Growing recognition that we can no longer afford what we have, how we distribute services and benefits, how we pay for care, and how we access care
- Rural communities have unique issues
  - Access along with coverage
  - Population that is poorer, older, and sicker
  - Health care in a rural community is a community and economic resource – how we see ourselves
Why the Need for Health Reform (continued)

- Approximately 46-47 million Americans without health insurance or about 16% of population – ND about 11-16% or 65-68,000
- 12-14,000 Americans lose health insurance every day
- 2,500 file for bankruptcy everyday due to health and medical costs
- Health care spending was $2.4 trillion in 2008 and expected to grow to $4.3 trillion by 2018
- Health accounts for 17.6% of GDP (20% by 2018)
  - France spends 9.5%
  - Canada spends 9.7%
- In 2008, about $7,900 per person was spent on health care in the U.S.
- U.S. spends about twice as much per capita on health care as other countries
- Health care spending is over 4 times that spent on national defense

Why the Need for Health Reform (continued)

- Insurance coverage
  - 60% of Americans have insurance from their employer (down from 66% in 2000) – ND it is about 62% - 53% of ND farmers receive insurance through non-farm source
  - 28% have insurance that is government based (Medicare, Medicaid and military)
  - 9% have insurance they purchase themselves
  - 15% are uninsured
- Average premium paid by a business for a family of 4 health plan - $12,700 (2008)
- Since 1999, employment based health insurance premiums increased by 120% while inflation rose by 44% and wage growth by 29%
- Premium growth for employer plans has been highest for small firms with less than 24 people
- Average employee contribution has increased more than 120% since 2000
- About 1.5 million families lose their homes every year due to unaffordable medical costs
Why the Need for Health Reform (continued)

- Health Status
  - U.S. ranks 28th in life expectancy (2008) in comparison to other countries*
  - 21st in age standardized mortality rate for cardiovascular disease (2008)*
  - 14th in age standardized mortality rate for cancer (2008)*
  - The Commonwealth Fund rates the U.S. last in health care system performance when compared to a group of six countries that include Australia, Canada, Germany, New Zealand and the United Kingdom. The U.S. spends twice as much as these six countries on a per-capita basis, yet it is last on dimensions of access, patient safety, efficiency and equity.*
  - Fewer physicians per capita (2.4:1000 U.S. vs. 3.1:1000 other industrialized countries)
  - 54% of U.S. patients do not seek recommended care, fill prescriptions, or visit a doctor because of health costs (7-36% in other countries)

*R United Health Foundation – America’s Health Rankings 2008

Rural Health Advocacy

- National Rural Health Association (NRHA)
  - Coverage does not equal access
    - Rural population is older, poorer, and sicker
    - Major rural issues include basic access issues such as workforce and keeping rural hospitals and clinics open
    - We can improve coverage but risk losing access points such as hospitals, clinics, ambulances, and providers
  - Rural focus
    - Workforce – National Health Service Corps, Health professions education improvements, expand rural residency programs, expand Medical School rural training tracks, incentives for rural medicine.
    - Medicare equity for rural facilities – improvements for Critical Access Hospitals and Prospective Payment System hospitals.
    - Improve access for vulnerable populations – Mental health workforce, rural veterans (tele-health, contracts with local rural health providers, mental health), outreach to uninsured rural children, rural impact study for significant Medicare changes.
Other Rural Health Considerations - Offered by the Center for Rural Health

- Rural health viability important for improvement of health status
- Rural health viability important to economic and community development
- Need for greater flexibility in health facility structures (new models of care – Frontier Extended Stay Clinic from AK)
- Need for greater flexibility to achieve better health outcomes and organizational performance (Medical Home Model)
- Need for rural communities and citizens to be advocates for collaboration, networks, and regional decision making

Health Reform Legislation and Rural Health

What is in health reform legislation that can impact rural health?

- Coverage for uninsured rural individuals
- Protects rural citizens from discriminatory practices e.g., pre-existing conditions, high out of pocket costs
- Rural payment inequities in Medicare reimbursement – IOM study
- Bonuses to rural primary care physicians practicing in shortage areas
- Pay rural physicians at same rate as urban physicians
- Pilot program for coordinated care in rural – Medical Home demonstration
- Expand Community Health Centers
- More training of primary care physicians in rural areas
- Incentive payments to physicians for cost efficiency
- Pays CAHs for reasonable costs associated with clinical lab tests
- Continues existing increase in Medicare reimbursement to rural ambulances
- Caps annual out-of-pocket spending for individuals (bankruptcy protection)
- Improves access to preventive services
Health Reform Legislation and Rural Health

What is in health reform that can impact rural health?

- Expands access to mental health
- Increased funding ($15 B over 5 years) to address rural health disparities like diabetes, obesity, tobacco use, and substance abuse
- Expands access to 340b drug program

A Rural Perspective on Health Reform

- Health insurance reform vs. health reform – is it the same or different?
- Rural health is concerned with both; however, system reform most important
- A role for rural communities and citizen input
- A long and complicated policy process
So where are we in March 2010?

• Over 1 year – Senate bill passed Senate and House bill passed House – consensus post Senator Brown election that each chamber can’t pass the other’s bill
• Health Reform Summit – was this theater?
• President’s proposal – not a bill but finally something on paper
• Budget Reconciliation or what else?

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