

Minnesota's Rural Health Care: There is no 911 to Call Steve Perkins

An open letter to the next governor of Minnesota:

Most people know that if you have a medical emergency, you call 911. We still have many people in our smaller rural communities, however, that would say, "You call the doctor," and that is what my mother did a few years ago when my dad died of an apparent heart attack.

This may seem strange to someone who has lived in a more densely populated area (we call metropolitan areas) all their life and has not even memories of a more trusting, close, and caring life (some might mistakenly call it simple) of our smaller communities, not just in rural Greater Minnesota but throughout America.

Our historical rural lifestyle

Governor, we can only hope you have both a real understanding and appreciation for rural lifestyle. If not, then we in Greater Minnesota must take action to get you, Governor, and I might add, metropolitan legislators, into Minnesota's great vastness to understand its heritage and how this rural heart really works. I am convinced that if we look deep enough, we will find answers to many of today's complex problems our fore-parents also faced but learned to solve by simply working together, helping each other out, communicating with one another, sharing and sacrificing together. When all else failed, they renewed yesterday's prayers for cures and asked God to help them bear the grief or failure and to endure life's hardships. Maybe if families just

practiced being families again, if we could revitalize the sense of community we once had and see a rebirth of faith-based and other community organizations, some of our problems would not be so insurmountable.

What does all this have to do with the problems we face in rural healthcare? It has everything to do with it. Rural people long ago realized that life was more than just quantity and a length of years, it was the quality of family, neighbors, friends and relatives, the community and everything it was and would be. Leaving this life only meant that you were going to a better one: it was called faith and everybody had it. The doctor was one of the town's most revered citizens. God healed people through his hands. The hospital was one of the key pivotal centers to each "big town" that had one, because after all only the big towns had hospitals, big stores and movie theaters, the circus, banks, and usually the courthouse. The hospital was where kids were born (starting just before WW II, when home birthing stopped, until today's natural birthing commenced), people had operations, and great healing occurred after heart attacks, strokes, pneumonia and a host of other ailments. Relatives and families always visited the hospital's patients. Most folks "had to leave the hospital and go home to rest up," I heard many times as a youngster while our family visited at the hospital.

Today's hospital and the community

Today's Greater Minnesota hospital is still the same institution. They still heal the sick and bring new life into the community, while some a few doors down depart this life for the next. Some hospitals still occupy the same original building, and the old timers refer to the Hill-Burton Act hospital as the "new one." They have been around a long time and always will be — or will they? Just who do you call when the hospital, the small town doctor, even the ambulance is sick and needs care?

What makes the question even more critical, pandemic to many rural towns, is that the hospital and medical clinic is a huge part of the local non-government economy. The best jobs with the highest pay are centered on the hospital. Other

than the school, the hospital and clinic represent the citizens with the highest education. At the core of local leadership and volunteers, you find people and their families that in many cases are directly tied to the hospital's existence.

Let me use my own community of Luverne as an example. The situation here would not materially differ from other smaller county seats so prevalent in Greater Minnesota. The hospital and clinic represents the largest employer at 220 employees, and if our two nursing homes are added (another 265 employees), the direct healthcare industry is nearly 500 people, better than 10 percent of the Rock County workforce. Hospital and clinic revenues are over one-fourth of all the items included in our community's gross retail sales. Clearly the economic impact would have significant adverse effects if any part of our local healthcare delivery system left the scene. To further illustrate, our local hospital has analyzed the effect of losing one general surgeon. In just a short time, a loss like that can take a positive-bottom-line hospital into an unsustainable negative. Other support employees start to leave, and a difficult-to-reverse downward spiral commences.

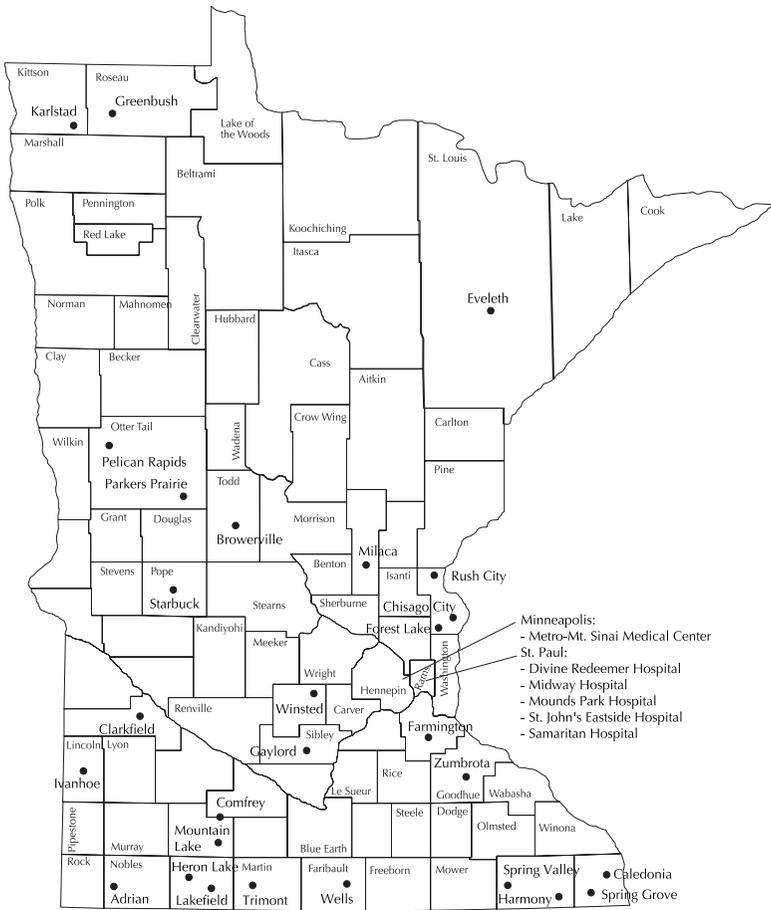
While the numbers of the financial impact are direct and convincing, ask anyone in Luverne what would happen if the hospital closed, and you would hear about a lot more than financial effects. In my opinion, a hospital's closing guts a community like nothing else, even more than losing your school, because no one, not even the elderly, wants to live in a community that does not have medical care. Further, the community's leadership, volunteers, and pride suffer immense damage. In essence, the very lifeblood of the community drains away, and all of this "patient's" critical stats start to "yell" alarm alerts.

Let me further illustrate my point from a recent interview with Ben Winchester, research fellow at the University of Minnesota Extension Center for Community Vitality, about research he is in the process of completing on community leadership. Ben finds that every community has both its physical maintenance needs and also, but many times forgotten, its social maintenance needs. Small communities populating Greater Minnesota are not the same towns and

villages of a few decades ago. Leaders were an abundant commodity into the 1980s when the World War II generation started passing from active community life to more passive roles, and a growing number actually began receiving for the first time in their lives versus giving. These activists were simply not replaced.

Today, Ben notes that in communities with fewer than 1,000 citizens, more than one in four community leaders will have to hold elected public office during their leadership career, but that number drops to just one in twenty for cities over 10,000. In addition to public office, our small rural communities have dozens and dozens of other private community, church and other non-profit groups to lead. Ben said, "To complicate matters the modern groups we are adding today are more activity oriented and less community centered."

The whole point, Governor, is for you to keep in mind with every bill you sign and every commissioner you appoint that every new increased regulation or requirement the state puts on essential community services has a cost. We only have so many leaders and volunteers in our rural communities to be volunteer ambulance attendants, firefighters, council members, Meals-on-Wheels drivers, leaders in the PTA, community clubs, Chamber of Commerce, our churches, the Red Cross, American Legion, and all the other groups and organizations that make our communities worth living in. If you make government so complicated that the mayor has to go to a host of out-of-town meetings to learn how to do this "volunteer job," then he or she won't be there to be on the ambulance squad. If you mandate more training hours for the EMTs or firefighters, we might have a better-trained department but so few volunteers that they cannot function. The hospital and medical clinics in rural Minnesota provide many of these leaders. Losing the hospital or seeing it decline will indeed have a big impact on the community far beyond healthcare and the walls of the hospital.



Source: Minnesota Department of Health
 Office of Rural Health and Primary Care

Figure 1: Minnesota hospital closures, 1987 to present.

The state of Minnesota's rural hospitals

Since 1984 America has lost nearly one-fourth of its rural hospitals. Minnesota had 168 acute care hospitals in 1987; today we have 134, and 28 of those 34 closings occurred in Greater Minnesota. The 1990s were particularly hard years and brought forth many rural facility closures. Figure 1 details those communities that suffered the hardship of closing a hospital. Many would argue that it is merely a sign of the times and necessary for the efficient practice of medicine. Likewise, hardware and clothing stores have closed.

Such is true, but nonetheless, the traumatic rippling effects throughout the community are far greater than a closing in the metropolitan area, where you simply travel to another part of the city for the same or better service, and there is no mass exodus of healthcare workers selling their homes.

Why did this happen? Many of the rural hospitals were simply too small to compete and maintain a strong market share in their ever-decreasing market area, combined with declining population. Lifestyle in the rural areas was changing and most doctors, particularly those entering the practice, did not want to pull 24-hour call in a two- or three-day rotation. Keeping a doctor in a small hospital setting with little money for new technology is difficult. Recruiting a new physician to such a facility and a small practice is impossible. Without doctors, these small hospitals soon starve out and close.

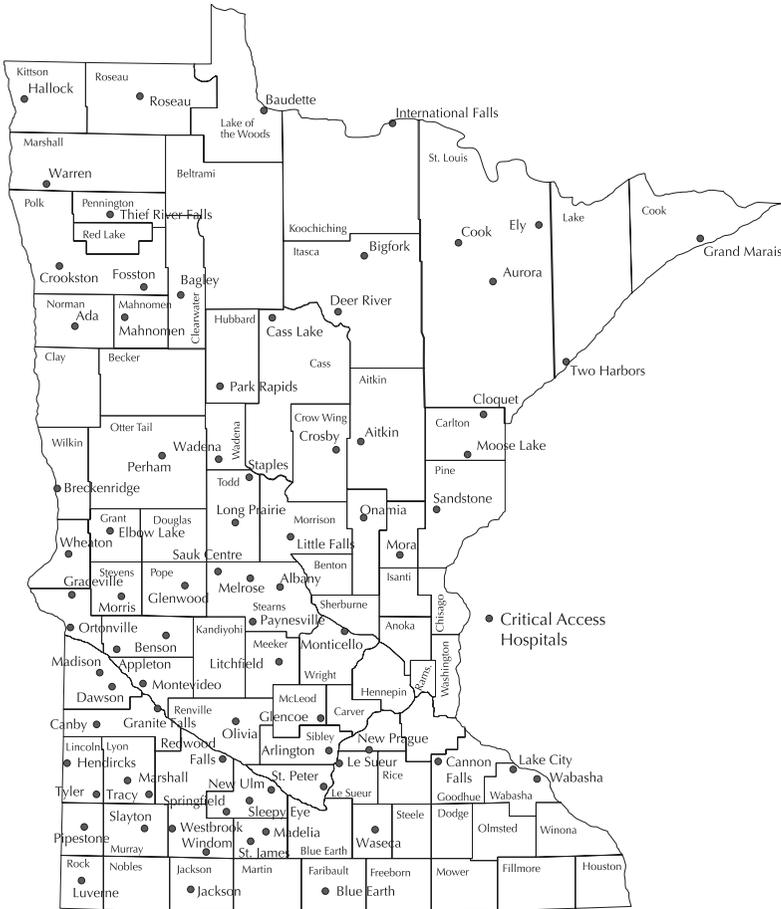
Will more follow? In my opinion the answer lies entirely in the ability of the hospital and the community to recruit quality physicians. Physicians will not come to an outdated facility or a depressed community. If the hospital's market area is not large enough to support at least three or four physicians and/or mid-level physician assistants or nurse practitioners, then the hospital should look at a different model while it has resources to change and become something new with longer-term possibilities. All of this will test the community's leadership to realistically look ahead and face the facts, the "hard, cold facts," never losing sight of reality, as Admiral James Stockdale, the highest ranking POW of the Vietnam War, would say. Many of these closures are related to more external factors beyond material control by the hospital.

Of course, there are internal factors that can lead to hospital closures as well. There certainly will be closings related to mismanagement. There are factors within the control of the hospital, which, if properly exercised, could positively affect its outcome and maintain financial viability. Just as businesses with potential close, the same factors affect hospitals, and most relate to having the wrong people in place at the wrong times. Hospital governing boards must exercise strong leadership and assure a competent CEO is at the helm. After all, it isn't just the hospital at stake but a large part of the community.

Critical Access Hospitals to the rescue

As previously noted, Minnesota lost a number of smaller rural hospitals in the 1990s. This phenomenon was not unique to us and, in fact, its effects were more pronounced in the deep rural areas to our west. In 1988 Montana became a Federal pilot project that was really the forerunner to our current-day critical access hospital. As Medicare's prospective payment system squeezed more money out of the reimbursement program and seniors required and demanded more care, rural hospitals with high percentages of elderly felt the pinch. The next year South Dakota got Congressional approval for its pilot project. In a few more years hunters, travelers, skiers, and hikers visiting from metro areas realized that even they may need emergency medical treatment in these well traveled but sparsely populated elderly meccas. Thus in 1997, after the closing of many rural hospitals, Congress passed the Medical Rural Hospital Flexibility Program, and the Critical Access Hospital (CAH) program began.

CAH allows smaller (25-bed maximum) limited-stay hospitals to be reimbursed based upon their overall cost of operation plus 1 percent. Usually, this reimbursement method amounts to more than the "one rate fits all" prospective payment system, where Medicare pays smaller, rural hospitals the same base amount as larger, non-CAH hospitals (with material adjustments based upon area and labor costs, etc.) for each diagnosis-related group ("DRG") illness or injury. For many small hospitals, it literally saved the day. It all depended on the case mix, the proportion of publicly funded to privately funded reimbursement. For many rural Minnesota hospitals, the case mix is about 50 percent to 60 percent Medicare, 5 percent to 10 percent Medicaid, and the balance private pay, with 1 to 2 percent charity care. The CAH program works well for these hospitals. It also helps for those hospitals with higher Medicaid, but it is not the complete life vest needed to stay afloat. Think of it this way: if you are only recovering your cost on half the business (Medicare) and you lose 15 percent on 30 percent of your Medicaid business, the 15 percent you make on the remaining 18 percent with 2 percent written off means you are still not breaking even. Thus CAHs in very poor areas



Source: Minnesota Department of Health Office of Rural Health and Primary Care

Figure 2: Critical Access Hospitals in Minnesota.

still have financial problems given the very low, below-cost reimbursements for Medicaid. Over time these hospitals will either have to change their case payment mix or risk closing.

Before Medicare closed the CAH program to new applicants, 79 of Minnesota’s 151 hospitals converted to CAH status. The economic benefits for many were by and large continued economic survival. As the above analysis shows, it did not take a long time for communities to do the numbers. I remember the Luverne board advised the Sanford system to

convert to CAH at one meeting; it was a true “no-brainer.”

In fact, in the western 100 miles of Minnesota from Iowa to Canada (the part of Minnesota west of a line from six miles east of Fairmont to eight miles east of Baudette), there are only eight non-CAH hospitals remaining: Worthington, Fairmont, Hutchinson, Willmar, Alexandria, Detroit Lakes, Fergus Falls and Bemidji. Fifty-two CAH hospitals serve this 40,000-square-mile area about the size of Ohio and larger than 16 of our states. Imagine if these 52 hospitals had not been able to stay economically viable and only the eight non-CAH hospitals were left to serve this 43-county area — the western half of Minnesota’s residents.

It isn’t just about keeping the doors open, however. CAHs with a more typical case mix have actually been able to make significant improvements over the last 10 years to plant and equipment. Ronald Wirtz in the Minneapolis Federal Reserve System’s *Fedgazette* pointed out in March 2007 that millions of dollars in new construction were being invested in district states. Of greater importance was the finding that a 2005 Stroudwater Associates and Red Capital Group study found that in 20 such improved facilities “admissions and total patient days increased, total staffing actually went down on an adjusted unit measure and earnings before various accounting charge-offs (so called EBIDTA) went up significantly.” This report concluded that “rural communities that built new CAH hospitals not only experienced increased market share, but also report enhanced clinical performance, improved workforce recruitment and retention, and improved quality performance.”

I can attest to this personally with Luverne’s experience of building a new hospital and medical clinic. Not only did efficiency, quality and gross revenue increase, but becoming a CAH consistently adds significant sums, at least half or more of total margin, to the bottom line. Converting to a Medicare critical access hospital was an obvious choice, and many states, including Minnesota, did all they could within Federal rules and regulations to permit hospitals to opt in.

Make no mistake about it, the CAH program did save and continues to save many rural hospitals. Without CAH, western

Minnesota would have more than eight hospitals, but many current CAHs that are clearly needed to provide emergency and convenient hospital care to considerable numbers of residents would not survive. In 2008, a decent year for hospital operations, 10 of 78 Minnesota Hospital Association CAH members had negative operating margins. Nine more had margins below \$300,000. Given the minimum \$500,000 ball park increase that CAH brings to a hospital's bottom line, it is conceivable that one-third to one-half of our current CAH hospitals could close in a five-year period if the CAH program were discontinued. Many of the remaining would be wounded soldiers in the community health fight. It truly is about access and maintaining basic life-sustaining services in our rural areas.

How far should people live from emergency medical care and at what population density? Is it acceptable that large areas of a thousand or more square miles (like Rhode Island or Delaware) with populations of 25,000 or more people would not have a hospital? Our climate does not allow for consistent air rescue and pick up or even dependable ground travel. Financial savings statistics would not soothe the nerves of a heart attack or hunting gunshot victim facing a 60-plus-mile trip to the nearest hospital. We have a greater percentage of auto accidents with deaths and serious injuries in rural areas. In America, 25 percent of the people live in rural areas, yet only 10 percent of our doctors practice there. CAH does more than keep rural hospitals open: it also allows them to recruit physicians and other health professionals essential to even basic-quality health care. Without the CAH program, much of rural Minnesota would be a medical ghost town.

While the CAH program breathed life into many rural facilities, it is not a perpetual panacea. In the long run, no one can operate a growing portion of their business on a 1-percent margin that does not allow 100 percent of the costs to be included; it also calculates the costs historically and does not pay prospectively. The small hospital still needs more, and if it is to continue to replace plant and equipment, it will need more debt coverage ratio than CAH provides. CAHs must have a constant eye on their patients' payers and also may

need the financial horsepower of a larger system to borrow the money for needed future major capital improvements. The old days of saving up are no longer possible. If your community is dying, the hospital might not be far behind. As Mitch Leupp, CEO of Mountrail County Medical Center in Stanley, N.D., said about CAH in the Wirtz article, "It is not a silver bullet."

Charge vs. cost: no relationship

Hospitals flourished in the 20 years following World War II. Medicare became a reality, and what had been a service financed by the private sector started to grow with the effects of tax dollars subsidizing the cost of care. We also expanded care for the poor from a mostly charity care-based system to one of government medical assistance or traditional welfare. Spurred by these new revenues, just as the technology explosion started, we experienced great strides and advances in medical care. At the same time, even small business started to offer employees and their families the benefit of free or reduced-cost healthcare insurance. In essence, families found a product that they could consume, and they only had to pay part of the cost.

Soon not only did patients stop asking the cost of a treatment or alternatives, but even doctors and hospitals stopped giving prices. It became too difficult to even give a price, and no one really asked anyway because someone else was paying for such a large part of it. In the 1970s and 1980s consumerism drove legislators to require morticians to give itemized charges, auto repair garages had to give estimates and could not bill for increases unless prior approval was given, landlords had to detail damage deposit withholdings, grocery stores had to show unit pricing, and a whole host of other such proposals hit the legislative bill hoppers, but doctor and hospital bills became incomprehensible even by the best educated. It really was more of a joke, because after all, Medicare or insurance handled these details.

The effect became even worse, in my opinion, on physicians and hospitals. So much time was spent on analyzing numerous and now dozens and dozens of reimbursement payment systems, healthcare providers forgot

to do what every other industry does, real cost accounting. Setting the price became more a guess and simply a percentage increase over last year and had little, if any, basis in the actual cost to provide such item or service. It was found in the \$5 aspirin. To the public it generates more laughs than serious questions to the provider because someone else is paying the bill. To providers, they realized that it really does not matter because no one pays the “retail rate.” Medicare has its way of paying, and medical assistance another, then the “Big Blues” negotiated hard for deep discounts. In essence, nobody with government or private insurance has a real idea of actual cost; even the doctors and nurses providing the service often cannot understand the system. As healthcare spending accounts (HSAs) are more fully understood by the consumer, questions and behavior are starting to change.

For a number of years I have asked almost every hospital or clinic CEO and CFO if they could tell me the costs of the various services they provided, much like I could tell them the exact cost of cut steak or a raised pig from my former businesses. To this day I have never found one that could. Some mentioned doing analysis when a new service or product was offered, but it really came down to what they could charge and what Medicare or some other large insurer would pay. Whether we made or lost money on an individual item or procedure seemed to be largely irrelevant. I did hear a lot that cost analysis in medicine cannot be done, because every person is different. The same could be said for many other industries. I do know that every pig is not the same: some get sick, some die. But understanding in detail the costs and the cost drivers and differences is critical to managing costs.

As costs continued to rise, the government programs simply cut more and more, which shifted the costs to the conventionally insured. The powerful big private insurers had more power and negotiated deeper discounts. The whole pricing system became absurd. One way to look at this is to look at what hospital-stated charges are versus actual payments (net revenues) received (not including bad debt), or in Medicare terms the “CMS charge-to-cost ratio,”

which is over 250 percent for Minnesota. Minnesota Hospital Association data shows that in 1988, stated charges for all hospitals were \$3.2 billion and the amount actually paid (net revenue) was \$2.6 billion, about a 20-percent discount. Twenty years later (2008) it was \$26.2 billion and \$12.2 billion respectively, more than a 50-percent discount. (This also represents an 8-percent gross cost inflation rate versus a general CPI rate of less than 5 percent.) Stated charges listed by a hospital is of little value in understanding what a hospital is unilaterally “given” by the government or “negotiates” with private insurance payment plans. While CAHs may appear to have some advantage in that costs are recovered, this really is only in an aggregate sense, and thus understanding what individual procedures and services actually cost is still imperative.

CAHs and reform: the art of politics

Today, Governor, with all the discussion of health care reform, for all the politics that have been played, and all the talk of change, it is the hope of many that we could truly look at healthcare through non-political eyes and hear the concerns of people without filtering the sound waves through partisan ears. If we do, (to paraphrase the Hippocratic Oath) maybe we can actually “prescribe regimens” that are accountable and monitored, and above all “never do harm” in the same way a lot of small rural towns apolitically decide issues of small and great importance.

For at least 30 years we have seen healthcare costs in aggregate rise by at least double the growth rate for other major economic sectors. Overall healthcare costs have risen to about one-third our entire national economy. We have heard from Washington a lot that the real concern is not only the percentage when compared to other industrialized countries but the trend. We continue to see costs rise substantially faster than the general growth rate of the economy. As Alan Greenspan told the American Hospital Association at its 2008 annual meeting, “If healthcare costs continue to rise like they have in the past 30 years, they will exceed the entire GDP in the next 30 years.” He quickly went on to acknowledge that

that was impossible by definition, but it detailed a hard fact: the increasing healthcare cost curve has to be more than bent. It needs to be cut, particularly with the pending increased utilization by Baby Boomers.

Not only is the Federal budget busting over healthcare costs, but we finance healthcare reform by taking \$500 billion out of Medicare to finance coverage for all while Medicare is already underfunded. *The Wall Street Journal* on January 8, 2010, noted that premier providers like the Mayo Clinic have started the process of no longer accepting Medicare patients at one of its Arizona primary care clinics. It is part of a two-year-long pilot by Mayo to see if additional facilities should be added. Clearly half of America's doctors will not take Medicaid and a rural Minnesota dental patient may have a day's drive to get essential dental care. State budgets including our own are also strapped with higher and higher healthcare costs.

So what about the American family? I recently saw data that shows American families are spending only 5.9 percent of their disposable income on health care. If it is a third of the economy and we are paying less than 6 percent of our pocketbook dollars, it seems no wonder what the problem is. What would happen if someone else paid such a significant part of our housing costs? What about food? Or clothing? Wouldn't everyone desire the penthouse apartment in the luxury apartment complex? We would all be shopping in the most expensive deli and eat at the best restaurants. For clothing, only the very best. The point is that the demand for healthcare service is nearly endless if the controlling buyer is only paying 25 or 30 cents, at most, on the dollar.

Now I can hear the feathers ruffling already, saying, "Healthcare is a right" or "We must have equal access for all regardless of financial status." I will not debate the point because I really believe only a very few would argue that we should allow sick people to die on our streets or be turned away from our hospitals because they have little or no ability to pay. To any who would advance this argument that medicine is a 100-percent personal responsibility, I would simply say, "Fine, you can site at the door to the emergency

room and tell those who cannot pay to go away.” Hospitals are the only business I know that are mandated by law (and have been for many years) to serve their customers knowing that they cannot pay anything. Truly, America is a Good Samaritan society, and we want to see our less fortunate friends and neighbors treated and cared for. I would, however, also advance the point that isn’t food, clothing, and housing also essential for life? We could also discuss education. The point is, Governor, we have to look at the cost and services provided even for the absolutely essential things for life. Not every part of medicine is essential for life. Capable individuals must also be accountable and responsible for that part of their wellness under their control.

This is where we can look back at what we find in almost every small town in Greater Minnesota. First, it is the core part of the community and its people that we are like a large family. If someone is sick, we care for them. We read their names in the newspaper and pray for them in church. Their condition is a topic around the coffee shop and the dinner table. It is a common occurrence to have a flier advertising a benefit dinner or auction to help someone in need. I honestly believe most small towns would start unraveling if homeless people curled up in downtown store alcoves. We not only have the same government programs as are available in the metro areas, but we also have massive communitywide support. Our churches, community funds and organizations are always helping. Charity and caring starts with each individual. It still happens that misbehaving kids are corrected by their community “parents.”

Whatever you do, Governor, please support this spirit that has glued us together from the days when it was all we had and the prairie fires, grasshoppers, and drought challenged our very existence. Make fun of it or whatever you will, but there is not enough money in our state or the entire country to begin to pay for public programs to replace America’s and particularly Minnesota’s commitment to one another so materially demonstrated in its small towns and rural areas. We take care of each other. Please, “never do harm” in this area.

So what comes next for our rural hospitals and Greater Minnesota healthcare in general? With the newly enacted Patient Protection and Affordable Care Act and the accompanying reconciliation act, what can we expect?

In reviewing the new law, there is some good news for rural Minnesota hospitals, but also the potential for adverse items. For example, the new law will give a 10-percent increase in Medicare reimbursements to primary care physicians and general surgeons in medical professional shortage areas (almost all of rural Greater Minnesota), but on the other hand, Congress instructed a new Independent Payment Advisory Board to cut \$13 billion from CAHs and physicians for FYs 2014-2020. While CAHs will now be able to participate in the outpatient prescription drug rebate program, there are penalties for even CAHs that fall in the bottom 25th percentile of hospital-acquired infections.

Clearly 30 million new people coming into the system with insurance cards in hand will have a big effect. While the effect in Minnesota may be felt less here since we have one of the lowest uninsured rates in the nation (number two behind Massachusetts), the payer mix could change. Depending on what a hospital's patient payer mix is, it could be good or not so good. This demand for primary care physicians could steal away our docs or those likely to replace them.

Generally speaking, but depending on what the Minnesota legislature does, we may see people actually moving from lower reimbursement rate Medicaid to private insurance plans. Minnesota currently covers families with children to 175 percent of the Federal Poverty Level and 150 percent for couples under Medicaid with its well-below-cost reimbursement rates. The new law takes this down to 133 percent and includes singles, which Minnesota covers by General Assistance Medical Coverage with even lower reimbursement rates for this very transient and multiple-illness population. If those "higher income" Minnesotans now covered by Medicaid find their way to private plans with individual tax credit premium subsidies, reimbursements could rise significantly. Individual state legislatures will have the right to determine if additional

subsidies are due to various income levels over what the Federal government provides.

In essence, it is difficult to determine how the new law will affect individual hospitals and providers without further analysis. Generally it should provide more money to well performing high quality hospitals (most in Minnesota are).

In the longer term I think we could well see a push for small individual hospitals to, at a minimum, coordinate and collaborate regionally. As the complexities of reimbursements and performance regulations increase, the need for more analysis and management talent also increases. We have seen this trend over the last 20 years. For example, in the far eight counties of southwest Minnesota, only one hospital is still independently owned and managed, while the balance are either owned or managed by one of the two large Sioux Falls-based systems — Avera or Sanford-MeritCare. In fact, Sanford MeritCare is now the largest rural healthcare provider in America.

The world gets even more complex in Minnesota as we look at a legislature that desires even more reform. So-called “baskets of care” is now the law, and while no hospitals have signed up to provide care at predetermined rates for certain treatments and/or chronic illnesses, it could well be a sign of what is to come. We are seeing providers that are applying to become Minnesota “healthcare homes.” In this program providers get monthly payments, between \$10 and \$60, to manage and coordinate the care of those with chronic conditions. It is hoped that with close management, outcomes can be improved and cost reduced.

Conclusion

In the end we do know that Americans spend up to 150 percent to 250 percent more on healthcare than any of the other industrialized nations. A number of physicians and medical practitioners would argue that these other countries get very good results, better than ours. Others would say there are problems in the data. It is true that we do an excellent job of medical treatment in America, which accounts for around a third of an individual’s overall health. The second third relates

to genetics: no one can cure poor genetics, but clearly the way we live our lives can reduce adverse odds and has everything to do with the last third, lifestyle and wellness. Most of America's healthcare cost is paid for by either the state and/or Federal government or private employers. Our international competitors by and large provide it as a government service paid for with tax revenues. Can America continue to compete if we finance our healthcare on our goods and services through employers?

Americans and Minnesotans clearly are saying they do not want to pay higher taxes but at the same time really have not shown any great desire to reduce consumption of government goods, particularly healthcare. Is this any surprise? Wouldn't we expect any good or service paid by and large by someone else to have increased consumption? There is little financial incentive for even a wellness lifestyle. Thus, until we deal with a realistic demand, either free-market based or artificial barriers (rationing), the present trend will most likely continue and providers will see smaller and smaller government reimbursements for services provided to an ever-increasing patient base.

The inefficient provider will fail, and those who do not know their true costs and work to reduce "the losers" will fail first. No one has the perfect crystal ball, but it is quite likely that we will see more and more "pay for performance" type reimbursement programs, and the likelihood of seeing parts of the former HMO like fully (or partially) capitated plans or baskets of care for disease specific treatment are high. It likely seems to be the only politically acceptable way to control demand. If we cannot control the aggregate cost through free market economics because everyone is entitled to quality healthcare, then the only way to control demand is to assure that only the most efficient best practices are being followed and paid for. How this will all work in the world's — beyond question — most litigious legal system remains to be seen. It is possible that we will see an expansion of what I call the "concierge physicians," those who for a fixed subscription fee provide 24/7 private medical service to their patients, which may simply be the beginning of a two-tier healthcare provider system.

While the future will be challenging, particularly for rural providers, I am convinced that the best and brightest providers will survive by finding their proper niche. Unfortunately for those that cannot, their rural communities will suffer a very big blow, when one of the traditionally best contributors to the community's financial and social capital will be gone, never to return. For them, there is no 911 to call.