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President's Message

What Needs To Be Reformed?

by John Steen

Lately, there have been a growing number of books and articles about what is wrong with American health care. There is certainly no lack of problems to cite, but most accounts somehow fail to focus on the basis for virtually all of the truly serious ones: The way that health care has become a big business, a source of profits second to none.

This issue lies at the heart of a great ideological divide in health policy. On one side of that divide you'll find conservative economic theorists (followers of Milton Friedman), business school professors, and the FTC, all pushing "free markets,"¹ "competition," and "consumer choice." On the other side, you'll find most physicians, most hospitals, and (what's left of) community-oriented health care and "the safety net."

The easiest way of defining the issues is to have an advocate of what you oppose who is truly articulate in representing his or her side. Regina Herzlinger, a professor at the Harvard Business School, is such a person. Her book *Market-Driven Health Care* (Perseus Books, 1997), was one of the seminal documents in promoting health care as a business, what she calls "entrepreneurialism," and she has just published *Who Killed*

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What Needs To Be Reformed?

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Health Care? (McGraw-Hill, 2007). Her side has given us concierge medicine, specialty hospitals, and “consumer-directed benefit design.” She would replace defined-benefit plans with defined-contribution plans, a step that amounts to “every man for himself.” She would have government policies reward those who display healthful behaviors (as if they weren’t already rewarding themselves), policies that would benefit the fittest (not the sickest), and further polarize the society. Her side advocates “consumer choice” to the extent of wanting the government to issue hospital report cards for consumers to use like Zagat restaurant guides.² Doesn’t she realize that most consumers have no use for a Zagat guide, though they might well wish they had? Some of us consume a lot less than others.

She makes it very clear that the issues are what health care is, and what role the government has in it. My side wants the government to regulate hospitals by setting and enforcing high standards that ensure superior outcomes everywhere, obviating the need for

“consumers” – *patients* – to “shop around.” We see quality assurance as a public health function, and health insurance as the socialization of risk. She sees us protecting the status quo at the expense of the consumer, but only the status quo has a safety net for the weak. In a recent editorial, she writes: “Time and again the regulatory status quo blocks entrepreneurship.... No wonder the 20 or so doctors enrolled in my class “Innovating in Health Care” at Harvard Business School are ruefully driven to earn MBAs once they realize they can innovate in medicine better as an entrepreneur than as a doctor.”³ I still find it bizarre that there are academics whose minds are so warped by their economic ideology that they can only see health care that way.⁴ Worst of all, it is clear how they see *people’s lives* – as statistics on a societal market spreadsheet for which the only goal is *efficiency*. It reconfirms my belief that health care is seen with far more insight by sociologists than by economists, especially conservative economists whose ideology would give us an ever more Darwinian society.⁵

The late Eli Ginzberg termed it “the monetarization of health care.” Transformation from a not-for-profit, community-oriented social system of health care into an industry has radically changed the behavior of providers and the experience of patients. It is not often noted in the U.S. that our physicians are entrepreneurs by virtue of how they are paid – by the procedures they perform – permitting if not encouraging them to enhance their incomes by doing more and more costly procedures.⁶ By contrast, in the rest of the world’s nations, physicians are largely working on salary, with no incentive to adopt more costly modes of care, and no incentive to concentrate on high-tech treatment rather than on the preventive and diagnostic modes of care that, along with meaningful communication with patients, is of greater efficacy in improving health status.

Regardless of how a health system is structured, its quality will always be a function of the conscience and dedication of its caregivers, so their ethos of devotion to their patients is priceless. How ironic then for us to see profit-driven, high-cost medicine as the price we pay for incentivizing physicians to perform well, instead of as a measure of the depreciation of professional life, the corruption of medicine.

The process of medicine’s becoming a business was well-described 25 years ago by Paul Starr, who traced the transformation of the power of American medicine, but today even that formidable power is compromised by the investor and business wealth that controls politics. Starr explained how in 1934 American medicine scrupulously fended off the involvement of investors interested in making a business of

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“Sicko” ... Socko ... Boffo

Fresh from a divine local John Waters film festival and seeking a fast-acting antidote, a bevy of east coast health planners recently screened “Sicko.” Surprise, Michael Moore’s cheeky tribute to unrequited pain and suffering was interesting throughout. Although much of the information was not unknown to old hands, these viewers were not very familiar with much of it, e.g., the French and Cuban health systems. Seeing it is recommended. Go. Enjoy. Cuba Libre... C’est Si Bon....

In early August, a little more than a month after the film’s release, a Kaiser Family Foundation poll¹ found that, although only 4% of adults had seen the film, another 42% had heard or read something about it, bringing the percentage of those who were aware of it to 46%. This total is less than the 61% who were aware of former Vice President Al Gore’s “Inconvenient Truth,” which was released more than a year earlier, but impressive.

Among those familiar with “Sicko,” the Kaiser Family Foundation poll found:

- 45% said they had a discussion with friends, co-workers, or family about the U.S. health system as a result of the movie, including 37% of self-identified conservatives;
- 43% said they were more likely to think there is a need to reform the system as a result, including 56% of self-identified liberals and 29% of conservatives;
- 37% were more likely to think other countries have a better approach to health care;
- 27% said they were paying more attention to the positions of presidential candidates on health care, including 18% of conservatives;
- 36% thought the movie accurately represents problems in the U.S. health system as opposed to 33% thinking it overstates them; and
- positive impressions of the film outweighed negative ones 48% to 33%, with 43% of self-



identified liberals having a very positive impression compared to 9% of conservatives; but

- when asked what has had the biggest impact on their opinions about the issue of health care recently, just 2% cited the film, 62% pointed to their personal health care experiences, and 9% said it’s what they have heard or read about proposals from presidential candidates.

Among the public at large, the Kaiser Family Foundation reports, 51% viewed health insurers, one of the film’s main targets, unfavorably, and 46% viewed the other major target, HMOs, negatively. Drug companies were perceived unfavorably by 52%, but hospitals and doctors were viewed largely favorably.

¹Kaiser Family Foundation news release, August 27, 2007. See www.kff.org. The poll was conducted as part of the *Kaiser Health Tracking Survey: Election 2008* August 2-8 among a nationally representative sample of 1,500 adults. Margins of sampling error were: plus or minus 3 percentage points for the full survey, plus or minus 4 for results based on respondents familiar with “Sicko,” and higher for results based on subgroups. ♦

Physician “Quality” Data

Officials of the Department of Health and Human Services (HHS) argued that releasing data on physician claims paid by Medicare could violate physicians’ privacy rights, but a U.S. District Court judge ruled in late August that the potential public benefit outweighed such concerns. The judge ordered that the data be turned over by September 21 in accordance with the Freedom of Information Act to the D.C.-based consumer group that had filed the lawsuit, Consumers’ Checkbook/Center for the Study of Services.

For now, the decision applies only to data from 2004 for D.C. and the states of Maryland, Illinois, and Washington, but Consumer’s Checkbook’s president was reported by *The Washington Post* on September 1 to have said that his group has requested data for 2005 for all states and does not expect that another court fight will be required to obtain it. The group plans, by later this year, to develop a reference tool on its website that will report the number and type of major procedures each physician performed for Medicare payment, with the goal of helping consumers to evaluate a doctor’s skills, e.g., assure that he or she has done an adequate number of bypass cases to be skillful. Consumers’ Checkbook hopes to get procedure counts from health plans as well, and plans to invite physicians to provide information on the total number of procedures they perform

The Center for Medicare and Medicaid Services was reviewing the court decision, as was the American Medical Association. But no appeal has been filed. The availability of individual physician procedure data by type would clearly represent an important step forward in making the health care system more transparent and, in principle, more responsive to consumers.

Possibly more well-meaning than beneficial at this point is the use by some health plans of their claims data to influence consumer choice of physicians. These plans are ranking physicians in tiers based on the plan’s assessments of the quality of the doctors’ services in accordance with best practice guidelines. Some plans require higher consumer co-payments for use of physicians in a lower tier. Although imperfect, some argue this effort is better than nothing. But is it?

So far available evidence, such as physicians being held accountable for lack of a mammogram and a physician being ranked in the top tier by one plan and in the second by another, indicates that all of the relevant questions have yet to be adequately addressed. Widespread physician objections may well have some merit. Consumers get what may very possibly be inaccurate recommendation from their plan. A consumer who can afford a higher co-payment might well be better off making an independent assessment until major issues are resolved. ♦



CON Metaphysics III

Free the CON Two

By Dean Montgomery

Many will recall the conviction last year of former Alabama Governor Don Siegelman and former HealthSouth CEO Richard Scrushy on federal bribery and related corruption charges. The principal charge, as summarily reported, was that Scrushy contributed \$500,000 to Siegelman's campaign for a state lottery in exchange for being appointed to the Alabama Certificate of Need (CON) Review Board, where presumably he could influence CON decisions.

Following closely on the heels of the indictment of Stuart Levine, an Illinois political wheeler dealer and a former Vice Chairman of the Illinois Health Facilities Review Board, for bribery, the indictment, conviction, and finally the jailing of Siegelman and Scrushy was not good news for planners and regulators. Critics, especially our doctrinaire friends, have been quick to cite these cases as confirmation that in any regulatory scheme the regulated always capture the regulators — provided the regulators are not wise enough to sell out before they can be rounded up.

Whatever their view on the inherent merits of planning and regulation, most of those who paid any attention to the matter probably accepted the convictions as just more sad commentary on the state of contemporary political and corporate culture. Given the colorful history of HealthSouth, Scrushy's repeated earlier escapes from multiple fraud indictments, and the hurly burly of Alabama politics, it was easy to conclude that, at least in Scrushy's case, justice may have been delayed but in the end not denied.

Well perhaps. But what if there was no bribery? What if Dick and Don are innocent victims of another nefarious plot, another example of federal prosecutors gone wild? This is not as farfetched as it might have seemed a year ago. Both Siegelman and Scrushy maintain their innocence, have appealed their convictions, and are calling on even higher powers to set the record straight.

Since the imposition of sentences earlier this summer, there has been a torrent of information and allegations that raise serious questions about both the prosecu-



tions and the convictions. Recent interesting developments include:

- Citing apparent irregularities, 44 former attorneys general (representing 40 states) have petitioned Congress for a formal investigation of the role of the Department of Justice in the prosecution;
- Both the House and Senate judiciary committees are interested in the matter;
- The House Judiciary Committee has requested case documents and related information from the Department of Justice, which, citing pending appeals, is refusing their release; and
- House Judiciary Committee staff is interviewing potential witnesses who appear to connect national and state Republican political operatives to the case.

The drumbeat for a full examination of the case appears to be growing.

Criminality or Business as Usual

Justice, a noble sentiment, is an illusive commodity. One cannot be certain of the facts in this case, much less of the intentions or understandings of the parties

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involved. Nevertheless, there is an odiferous quality to the case that commands attention. Apparently, there is no evidence of a “quid pro quo” arrangement, presumably the *sine qua non* for bribery. Siegelman received no payment or other economic benefit. Scrushy’s arranged payment went to the Alabama Education Foundation, which was established to promote the creation of a state lottery to support public education. Similarly, there is no evidence that appointment of Scrushy to the Alabama Certificate of Need Board was payment for that contribution or any other. He had already served on the Board several times, appointed previously by three governors, including Siegelman. Apparently, HealthSouth had no business pending before the CON Board.

To the outside observer, the “arrangement” appears remarkably similar to “political” contributions and appointments that occur regularly nationwide, say in a perfectly noble state such as Maryland. In other words, it fits the “business as usual” pattern found in virtually every state. It is not peculiar to Alabama or to certificate of need regulation. The most unusual aspects in this case are the size of the public-spirited “contribution,” the opaque way Scrushy arranged the payment, and the fact that it did not go to an entity controlled by the governor. None of these considerations make much sense under a “quid pro quo” arrangement: the “bribe” is too large and economically inefficient, and Scrushy’s arranging for half of the contribution (\$250,000) to be paid by a shaky Maryland corporation on whose board of directors he and some other HealthSouth officials sat, may speak volumes about HealthSouth business practices but does not suggest any connection to, or impropriety by, Siegelman.

Likely Developments

We are likely to learn a bit more about this case. It appears likely to become an important element of the congressional investigations of the Department of Justice under Alberto (aka Judge, Fredo) Gonzales. Congressional investigators were interviewing potential witnesses on the day Gonzales was being ceremoniously returned to Texas. Unlike Scrushy, he will not be reporting to the federal prison in Beaumont.

Those wishing to know more or to follow developments can do so by monitoring the websites supporters

and opponents of Siegelman have established. They are located at:

- <http://donsiegelman.org> [Pro Siegelman]
- <http://www.thetruthaboutdon.com> [Anti Siegelman]

You may also want to follow developments by reading Scott Horton’s *No Comment* blog in *Harper’s* magazine. Horton’s reporting and commentary is particularly well informed and well written. His commentary can be found at: www.harpers.org/subjects/ScottHorton.

Apparently, Scrushy is putting his faith and hopes in both attorneys and a higher power. See <http://www.scrushy-ministries.com>

So all of you planners and deciders take heart. Even Scrushy may be innocent, at least in this instance. And, just as pitching is more rewarding than catching, perhaps giving may actually be better than receiving. Scrushy, the generous contributor to the campaign for a state lottery, got a shorter sentence (6 years, 10 months) than Siegelman (7 years, 4 months). Both men also got three years probation, fines, and restitution. But, in contrast to prison sentences, Scrushy’s fine and order restitution (\$417,000) was higher than Siegelman’s (\$231,000). Scrushy also must pay nearly \$2,000 a month for the privilege of occupying a federal prison cell. Apparently, Siegelman is not required to pay for his downsized public accommodations. Justice may be blind, but political justice only myopic.

More to the point, the Lord surely do work in mysterious ways. **Lordy** ... Lordy...lordy.

¹Levine pled guilty and is cooperating with federal prosecutors. He has yet to be sentenced. Apparently, the Illinois Health Facilities Review Board irregularity was not Levine’s only or even major problem.

²Apparently, Integrated Health Services (IHS) an aggressively and disastrously managed provider of “sub-acute” long-term nursing care contributed half of the \$500,000. Scrushy and other HealthSouth officials were members of the IHS board of directors. IHS failed and was taken over by a third party in 2002. ♦



Policy Perspective

By John Steen

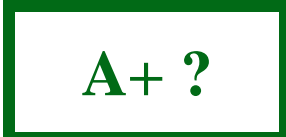
Hawaii: Regulation Works

In the last quarterly issue, we reported on recent rankings of states for the performance of their health care systems, noting that the extent of a state's health insurance coverage is the best predictor of its performance. Hawaii topped the list for overall performance and had the third lowest percent of uninsured adults (close behind Minnesota and Iowa). It is worth noting that Hawaii's success here is largely due to its rigorous regulation of its insurance industry. All employer-provided health benefit plans must be approved by the Prepaid Health Care Advisory Council in compliance with the state's Prepaid Health Care Act. This act requires employer coverage to meet if not exceed a state-defined set of benefits. It controls employee premium contributions (as a percent of the employee's income), as well as deductibles and co-payments. It also uses community rating and outlaws pre-existing condition limitations. The act precludes use of "consumer-driven" plans like health reimbursement arrangements (HRAs) and health savings accounts (HSAs).

The act's employer-mandate effectively regulates the small group market, an approach unique to the state because it gained a federal exemption from the constraints of ERISA, which passed in the same year as the act (1974). Hawaii is the only state that is able to require all of its employers, even those who are self-insured, to provide health insurance to most of their workers.

Grading a Report Card

We're only too familiar with all the hype about the *US News & World Report* annual list of "America's Best Hospitals." Researchers at Yale University School of Medicine and Harvard Medical School decided to find out whether the 50 hospitals selected for the best cardiovascular care achieved superior outcomes for myocardial infarction (MI or "heart attack"). They used a hierarchical regression model based on 2003 Medicare administrative data for risk-adjusted 30-day MI mortality to differentiate the quality of care at cardiovascular centers.



The magazine's 2003 rankings for "heart and heart surgery"¹ were reached using three equally-weighted categories: in-hospital mortality associated with a range of cardiovascular disorders, hospital infrastructure (high-tech services and resources, and nurse ratios), and reputation among the surveyed cardiologists. The 50 centers (13,662 patients) on their list did perform significantly better than the other 3,813 cardiovascular centers (254,907 patients) with mean mortality figures of 16.0% and 17.9% ($p < 0.001$), respectively. But the range of mortality figures for each group was wide and overlapping, 11.4-20.0 and 13.1-23.3, respectively. And there were only 11 centers with truly superior standardized mortality ratios among the 50 ranked by the magazine, but 28 among the 3,813 unranked centers.

The Yale/Harvard authors believe that the weighting for reputation is largely responsible for the discrepancy in differentiation based on MI mortality. Asked to identify those centers that provide the best care for the most difficult cardiovascular cases, the authors write that cardiologists surveyed name "tertiary care centers with strong subspecialty care for the most critically ill patients, while not necessarily reflecting the perceived care for the overwhelming majority of admissions for more common diagnoses, which in turn have a more substantial impact on overall hospital outcomes."²

California Reports Cardiac Surgeon Outcomes; CABG Declines

On July 12, the California Office of Statewide Health Planning and Development issued the state's first report on coronary artery bypass graft (CABG) outcomes by surgeon.³ California is now the fifth state – after New York, Pennsylvania, New Jersey, and Massachusetts – to do so. The report covers two years, 2003 and 2004, and includes 302 surgeons and 121 hospitals. The state's average 30-day risk-adjusted mortality for this surgery for the two years was 3.08%, a very poor performance compared to New York's gold standard of 2.2% and the national rate of 2.4%.⁴ Also, the state's performance has been worsening. It was 2.91% in 2003, and 3.29% in 2004.

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One might hope that the legislature will now come to appreciate the value of state health planning with certificate of need regulation to regionalize such services in order to produce higher volumes per hospital and per surgeon.⁵ The state has been averaging about 165 surgeries per hospital and 65 per surgeon. Ideally, rates should be about three times those ratios; in New Jersey, a surgeon has to perform at least 100 per year simply to practice CABG surgery. And California rates have been declining as percutaneous coronary intervention (PCI) increasingly replaces CABG. Between 1997 and 2005, PCI increased almost 35%, while CABG decreased about 39% in the state, reducing the average number of CABG surgeries per hospital to 142 in 2005. However, the report found no significant association between the number of CABG surgeries that hospitals perform annually and their risk-adjusted mortality rates.

The Agency for Health Care, Research and Quality (AHRQ) reports that nationally, the number of angioplasties nearly doubled from 1993 to 2005, rising steadily from 418,000 to 800,000 a year.⁶ By contrast, CABG surgeries rose slowly from 344,000 to 426,000 a year between 1993 and 1997, and then declined steadily to 278,000 a year by 2005. Although hospital stays in 2005 for angioplasty are much shorter than they were in 1993 (an average of 2.7 days instead of 4.6 days), hospital charges have increased by more than 50% during the period, rising from \$31,300 to \$48,000 (adjusted for inflation).

Validating Quality Measures

The growing use of practice guidelines is grounded in the proposition that their use will lead to improved patient outcomes. Practice guidelines are based on condition-specific process measures for performance, adherence to which is thought to constitute good medical care for those conditions. Researchers at the Harvard School of Public Health and Brigham and Women's Hospital have now examined the relationship between hospitals' performance on Hospital Quality Alliance (HQA) indicators and mortality rates in order to test the validity of that relationship as promoting quality of care.⁷

HQA is a national public-private collaboration supported by the Center for Medicare and Medicaid Services (CMS) to encourage hospitals to voluntarily collect and report hospital quality performance informa-

tion on three common medical conditions – acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia – which, according to the researchers' study, account for more than 15% of Medicare hospital admissions. The researchers used data from 3,720 hospitals for care provided to Medicare patients age 65 or older from April 2004 to March 2005. They looked at 10 quality-of-care indicators related to treatment of those three conditions. They then linked these indicators to Medicare data for risk-adjusted (for patient age, sex, race, and the presence or absence of each of 30 comorbidities) mortality rates at discharge, and found that higher performance was consistently associated with lower mortality rates. Compared to hospitals in the bottom quartile of HQA performance, those in the top quartile had 11% lower mortality for acute myocardial infarction (AMI), 7% lower mortality for congestive heart failure (CHF), and 15% lower mortality for patients with pneumonia. Projecting their findings to the nation as a whole, they conclude that if hospitals in the bottom quartile had mortality rates comparable to those in the top quartile, 2,200 fewer Americans would die each year from the three conditions studied (474 for AMI, 627 for CHF, and 1,112 for pneumonia).

These findings did not change significantly even after controlling for hospital characteristics like teaching status, region, size, and urban/rural location. And the strength and consistency of the associations suggested to the researchers that the measures identify hospitals that provide high-quality care beyond the specific parameters of HQA processes. They believe their findings to be sufficiently robust to encourage patients to use published data on hospital quality in making decisions about where to go for their health care, stating that the mortality benefit of being a patient in a top-quartile versus a bottom-quartile hospital is comparable to that of receiving a beta blocker after an AMI versus not receiving one.

As caveats, they noted that the study was limited by the use of just three conditions as quality indicators and by the use of administrative data to perform risk adjustment for in-hospital mortality, limiting the ability to fully account for differences in underlying risk among patients. They also noted that data were obtained from Medicare files and thus only looked at outcomes in older patients,

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while the performance measures are applicable to younger patients as well.

A study published last year using a similar methodology found the same correlations for the same three conditions and deemed them statistically significant, but so small that “the ability of performance measures to detect clinically meaningful differences in quality across hospitals is questionable.”⁸ The greatest import of the two studies is in each finding that outcomes track process measures, thus validating the HQA methodology.

N.J. Commission’s Interim Report on Hospitals

On June 29, the New Jersey Commission on Rationalizing Health Care Resources, chaired by Uwe Reinhardt, issued an 87-page interim report evaluating the condition of the state’s 80 hospitals.⁹ Via Executive Order in October 2006, Governor Corzine charged the Commission with advising him “on means to support a system of high-quality, affordable, cost-effective and accessible care” to “ensure that taxpayer dollars are spent wisely, to help meet New Jersey’s healthcare needs in a sustainable way, and to enhance oversight and accountability.” Among the ten specific tasks included in its charge is to “review existing Certificate of Need statutes and regulations to ensure consistency with State health care needs, and recommend amendments and/or revisions to achieve that objective if necessary.” The Commission was charged with producing a final report by July 1, but the governor has since extended that deadline to December 1.

In its interim report, the Commission focuses on the financial and operating condition of the state’s hospitals, and on developing criteria to assess how essential those that are financially distressed are to health care access. The Commission cites as prior relevant research it has reviewed the *Final Report* of the Berger Commission in New York State (December 2006)¹⁰, and the research of The Dartmouth Atlas Project. It should be noted that the Commission is only advisory, without the power given the New York Commission to close hospitals and nursing homes.

The impetus for these New Jersey and New York planning initiatives is implicit in a chart that appears in the

NJ interim report. Three of its dimensions for comparison of area acute care hospital systems are shown in the table below.:



The New Jersey Hospital Association’s comments on how the Commission is evaluating the essentiality of hospitals state that “the proposed framework needs to be grounded in comprehensive statewide health planning. At present, it lacks that context. The framework needs a statewide health plan for all healthcare services (not just acute care) in order to make sense.”¹¹ The Association also states that the Commission must examine and address the proliferation of ambulatory care centers.

It is occasions like this when public policy issues are aired publicly that provide an accounting of problems in health care delivery that don’t usually come to light. The Hospital Alliance of New Jersey is composed of a set of urban “safety net” hospitals that was established in 1993, a year after the legislature deregulated health care, leading eventually to the crisis now being dressed. On April 30, it submitted testimony to the Commission in which it stated: “Since one of the express purposes of the Certificate of Need program is to balance government regulation against market forces, in addition to increasing reimbursement for charity care and Medicaid services for our urban centers, it is the responsibility of our policymakers to review our Certificate of Need program to ensure that urban centers can attract some insured, paying patients to the cities to offset the care provided to those without insurance.” And on ambulatory surgery centers (ASCs) it had this to say: “Because there are issues of quality care and non-regulation involved in these doctors’ offices, we suggest that the Commission support the implementation of a regulation that states that ASCs that are unregulated by the Department of Health must include that

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that disclaimer in their advertisements to the public.” It further proposed that ASCs be required to provide a certain amount of charity care each year.¹²

¹US News & World Report. *The 2003 Index of Hospital Quality*. Available at: http://www.usnews.com/usnews/health/best-hospitals/methodology/ABH_Methodology_2003.pdf.

²⁰O.J. Wang et al., "America's Best Hospitals' in the treatment of acute myocardial infarction," *Arch Intern Med* 2007; 167:1345-1351 (July 9, 2007). <http://archinte.ama-assn.org/cgi/content/short/167/13/1345>.

³<http://www.oshpd.state.ca.us/HQAD/Outcomes/Studies/cabg/200304HospSurgReport/index.htm>.

⁴Society of Thoracic Surgeons: *Spring 2005 Report - Adult Cardiac Database Executive Summary*, 24 October 2005

⁵Last year, Wilma Chan, Chair of the Assembly Health Committee, requested a report on what happened to California's hospital CON program. One was produced in August, 2006 that can be accessed at <http://www.library.ca.gov/crb/06/09/06-009.pdf>.

⁶See <http://hcupnet.ahrq.gov/>

⁷A. K. Jha et al., "The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures," *Health Affairs*, 26(4): 1104-10 (July/August 2007). <http://content.healthaffairs.org/cgi/content/abstract/26/4/1104>.

⁸Rachel M. Werner and Eric T. Bradlow, "Relationship Between Medicare's Hospital Compare Performance Measures and Mortality Rates," *JAMA*, 296:2694-2702 (December 13, 2006). <http://jama.ama-assn.org/cgi/content/full/296/22/2694>.

⁹Accessible at http://www.state.nj.us/health/rhc/documents/interim_report.pdf.

¹⁰This *Final Report*, as well as the creation of the New Jersey Commission, was covered in "Is This Any Way to Do Health Planning?" *Health Planning TODAY*, 4th Quarter 2006, pp.5-6. http://www.ahpanet.org/files/Steen_IsThisAnyWaytoDoHealthPlanning_07.pdf.

¹²In a Message from the Governor at the Commission's website, <http://www.state.nj.us/health/rhc/index.shtml>, Gov. Corzine says, "I strongly believe it's time New Jersey had a sensible state health plan." The state hasn't supported regional health planning since its Local Advisory Boards were defunded in 1996-97. The website also posts relevant documents submitted by interested parties, including "[Certificate of Need Laws: Analysis and Recommendations for the Commission on Rationalizing New Jersey's Health Care Resources](#)," Janelle Sagness, January 12, 2007. [PDF 75k]

¹²*Inpatient Quality Indicators, New Jersey 2005*, New Jersey Department of Health and Senior Services, Office of Health Care Quality Assessment, July 2007. Available at: <http://www.state.nj.us/health/healthcarequality/documents/iqi2005.pdf>.

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medicine by adopting a code of ethics to prohibit profit making from the practice of medicine. Whatever capital might be necessary to fund its practice, e.g., to establish a hospital, would be contributed by *the community* that would benefit by it.

What has since been transformed is the value system of health care, from Samaritan hospitals nourished by their community roots to investor ownership of facilities and control of caregivers as instruments for profit making. For-profit hospital chains have acquired community hospitals, destroying their fiduciary role for their communities, and often closing them simply to eliminate a competitor for market share. It has also been called "the commodification of medicine,"⁷ and it represents the triumph of greed.⁸ Worst of all, that greed, masquerading as market ideology, has not only corrupted the ethos of health care, it has subverted the principles of our democracy in the interests of feeding itself.⁹

Paul Starr explained how this was possible in the very first sentence of his book *The Social Transformation of American Medicine*: "The dream of reason did not take power into account."¹⁰ As one who entertains "the dream of reason," I'm inclined to want to speak truth to power, never more so than now that rationalizing health care delivery is once again taking its proper place on our national political agenda. And yes, I do write as an idealist, but my idealism is a form of resistance. I wish to see a national debate that addresses what is needed rather than merely what is politically feasible, avoiding the trap of offering only partial solutions. My hope is that the time has once again come to, in that celebrated phrase of Teddy Roosevelt's, "dare mighty things," recapturing the promise of America in the spirit that has always defined it, a nation once again aiming at a common good.¹¹ We haven't dared mighty things since The Great Society gave us Medicare and Medicaid and Bill Moyers said, "Ideas are great arrows, but there has to be a bow. And politics is the bow of idealism."¹²

We have a moral responsibility to act on what we know, and to seek to improve our knowledge and understanding when the welfare of others is involved. In such a situation, not to act is a moral failing.

Because I see this as an ethical enterprise on a political scale, I believe that the public's judgment on it needs to

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be informed political consent. We need to have sorted out and achieved some consensus on our core political values and given them some currency in political discourse, to be “presupposed and operating in the background” as John Rawls said,¹³ if we are not to lose our way in seeking solutions to seemingly intractable problems.

I now see an opportunity, the first since 1994, to reframe the health care debate at a higher level of political discourse by *asking the right questions*. Those questions should address the premises of the social contract, those on which our political system is based. The political process can deliver a product befitting our nation only if it is carried out at a level at which our highest national values are accessible. Only by raising it to such a level can we escape being once again mired in the morass of myths, prejudices, and lies that have characterized it since 1994.

We live in a liberal democratic state, one that values individual freedoms.¹⁴ It also values as priceless the worth of individuals as ends in themselves, a value derived solely from the humanity they have in common, a quality that does not vary according to their health nor to their instrumental value to society. This notion of the good in which liberty and equality are joined, together with a sense of justice as fairness, are what citizens need to exercise good judgment in the political arena.¹⁵ It is pluralistic, not unitary, but there is what John Rawls called an “overlapping consensus” of compatible views,¹⁶ and that consensus is what makes a just polity possible. For an egalitarian health care system to ensue from political consensus, that consensus must also embody communitarian principles. Here in the U.S., we lack a European sense of social solidarity, having instead the social Darwinism we like to call “rugged individualism.” However, the latest data in social epidemiology strongly suggest that such “rugged individualism” is even more antithetical to improving our health status than are the differentials in health care access it supports.¹⁷

We should understand what the gold standard in health policy is before politics and policy clash. Empowering the electorate to do the right thing for everyone in our nation involves educating it before it is put in a position to compromise in the inevitable political negotiations. Those negotiations will seek a

good, not a perfect result, but to achieve it, someone must advocate for the perfect. Health is too precious in its own right and too requisite for all else not to. We must be aware of the societal cost of allowing the good to be the enemy of the perfect ... too many priceless lives are involved.

“Power concedes nothing without a demand. The struggle or justice must never be adjourned. The forces of injustice do not take vacations. Societies are not static in this regard. They await the political and civic energies of individuals who engage the arenas of power, multiply their numbers and emblazon in deeds and institutions the immortal principle that ‘Here the People Rule.’”

— Ralph Nader, , in the pamphlet *Civic Arousal*

“The dream of reason” in American politics is that we distribute societal goods on an egalitarian basis, but such is clearly not now the case. We are all ultimately responsible for the conditions in which Americans live, conditions that can be seen as human rights abuses. That so many Americans lack health insurance, with the attendant inequities in access and disparities in health status, qualifies as one such abuse. “Human rights violations are not accidents; they are not random in distribution or effect. Rights violations are, rather, symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm.”¹⁸ We will never see the problems in American health care until we see our own hypocrisy in how we defend our shortcomings.

*“If a nation expects to be ignorant and free
in a state of civilization,
it expects what never was and never will be.”*

— Thomas Jefferson

¹⁴For an analysis of the absence of “free market” conditions in health care, see R.G. Evans, “Going for the gold: the redistributive agenda behind market-based health care reform,” *J Health Polit Policy Law* 1997;22:427-66; and T Rice, “Can markets give us the health system we want?,” *J Health Polit Policy Law* 1997;22: 383-426. While “competition” constitutes the dominant ideology for economists, it is seen more clearly by anthropologists as one of our society’s principal “myths,” conveniently used to explain and justify the economic activity of business. What is left out of the conservative economic and political accounts is how the limits to competition in the form of norms, rules, laws, and social institutions, for which government is

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responsible, are necessary for it to produce social goods. This was well documented by Amitai Etzioni in his *The Moral Dimension* (1988).

²An edifying example of her arguments, and proof that I've not misrepresented her, is available in an online interview: Robert S. Galvin, "Consumerism and Controversy: An Interview With Regina Herzlinger," *Health Affairs*, 24 July 2007. <http://content.healthaffairs.org/cgi/content/full/hlthaff.26.5.w552v1/DC1>.

³"Where Are the Innovators in Health Care?" *The Wall Street Journal*, July 19, 2007. <http://www.manhattan-institute.org/html/wsj-where-are-the-innovators-in-health-care.htm>. Intelligent regulation limits greed, and that may be a better explanation of why she has those 20 MBA students.

⁴Richard A. Epstein is the most prominent proponent of the conservative/libertarian tradition established by Milton Friedman at the University of Chicago where Epstein directs the Law and Economics Program, and like Friedman, is a senior fellow of the Hoover Institution at Stanford. His new book, *Overdose: How Excessive Government Regulation Stifles Pharmaceutical Innovation*, is well critiqued by Arnold S. Relman in "To Lose Trust, Every Day," *The New Republic*, July 23, 2007. <http://www.tnr.com/doc.mhtml?i=20070723&s=relman072307>. Relman reveals how far from reality Epstein's ideology takes him.

⁵"None of the prominent universal health care proposals does anything to alleviate spending because none would have patients choose between health care and other uses for their money." Devon Herrick, National Center for Policy Analysis, July 24, 2007. http://www.ncpa.org/sub/dpd/index.php?Article_ID=14806. No comment from NCPA here about alleviating suffering. Conservative economists seem to see health insurance only as a "moral hazard" contributing to greater spending.

⁶Among the few exceptions are the salaried physicians in the Veterans Health Administration System, those who work for some large insurers like Kaiser Permanente, and some who are employed by large group practices.

⁷Edmund D. Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic," *Journal of Medicine and Philosophy* 24, no. 3 (1999): 243-66.

⁸The threat to public health was noted by Toby Citrin in an editorial in which he upholds its unique role as the legitimate advocate of the community that validates it. Toby Citrin, "Public Health – Community or Commodity?" *The American Journal of Public Health*; 88:3 (March 1998): 351-352. <http://www.ajph.org/cgi/reprint/88/3/351>.

⁹For an admirably clear, up-to-date documentation of this, see *Market Based Health Care: Big Money, Politics, and the Unraveling of*

U.S. Civil Democracy, Institute for Health & Socio-Economic Policy, June 22, 2007. Accessible at: http://www.calnurses.org/research/pdfs/ihsp_marketbasedhealthcare_062607.pdf. The Institute is a non-profit policy and research group that includes an advisory board comprised of scholars from the Albert Einstein College of Medicine, Boston University, Harvard University, the Canadian National Federation of Nurses' Unions, the New School in New York, and the University of California. Its report (pp. 9-11) details how in 1993-94, the Department of Justice and the Federal Trade Commission contravened their own antitrust, pro-competition principles in the interest of promoting the development of mergers and networks to enable greater profits.

¹⁰New York: Basic Books, Inc., 1982, p. 3

¹¹In the past century, the suffragette and the civil rights movements furnish instructive examples of successfully operationalizing ideals as political principles that expanded our body of laws founded on human rights.

¹²*Time Magazine*, October 29, 1965.

¹³Stated in several of Rawls' works, including *Political Liberalism* (Columbia University Press, 1993)

¹⁴But we don't do a very good job of defending them. See http://action.aclu.org/site/PageServer?pagename=AS_why_care_about_civ_lib.

¹⁵John Rawls, "Justice as Fairness: Political, Not Metaphysical," *Philosophy and Public Affairs* 14 (1985): 223-251.

¹⁶John Rawls, "The Idea of an Overlapping Consensus," *Oxford Journal of Legal Studies*, 7, no. 1 (1986); "The Domain of the Political and the Overlapping Consensus," *New York University Law Review* 64 (May 1989): 233-255; *Political Liberalism* (Columbia University Press, 1993), p.15.

¹⁷There is a new appreciation for the roles of social justice and social capital in improving health. See for example N. Daniels, B. Kennedy, and I. Kawachi, "Why Justice Is Good for Your Health: Social Determinants of Health Inequalities," *Daedalus* 128, no. 4 (1999): 215-51, and I. Kawachi, B. Kennedy. *The Health of Nations: Why Inequality Is Harmful to Your Health*. (The New Press, 2002).

¹⁸Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. With a foreword by Amartya Sen (University of California Press, 2003), p.7. Dr. Farmer argues that there are three approaches to improving health care – charity, development, and social justice – but only social justice is adequate to the task. (p.152) And Amartya Sen argues that development is not the acquisition of more goods and services but what he calls "capabilities," the freedom to live the kind of life one chooses to live. In *Development as Freedom* (Knopf, 1998), pp. 87-110. ♦

To AHPA Members: A Call for Nominations

The American Health Planning Association (AHPA) is seeking nominations for positions on the Association Board of Directors. Directors are elected for three-year terms. Those elected in 2007 will begin their terms on January 1, 2008. All AHPA members in good standing are eligible to serve on the Board.

There are four association board meetings each year, as well as occasional committee meetings and conferences and other special meetings. There is no compensation. Board members are responsible for the expenses they incur in attending meetings.

The current AHPA Board believes the aim of health planning to be the development of community-oriented health systems designed to facilitate and promote access to necessary care of the high quality and reasonable cost. The Board also believes that a public decision making process that is sensitive to community values, to the concerns of consumers, providers, payers, and to the needs of under served populations offers the best way of assuring accountability and equity in the design and direction of the future health care system. Information on AHPA policies and activities is available at the Association's website: www.AHPAnet.org.

If you are interested in being nominated, or wish to nominate another member, please complete and return the nomination form on page 14 by September 28, 2007. Your involvement and support is needed and invited.

If you have questions or require additional information please call (703) 573-3103 or email us at AHPAnet@aol.com.

— Dean Montgomery, AHPA Nominating Committee



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Anything Interesting Going On ?

Surely something of interest to health planners has occurred — or is going on — in your state, region, office, or whatever. Share it and its implications with others!

The deadline for the next issue of this newsletter is December 1, which gives you plenty of time to write it up and gain fame, if not fortune.



AHPA Board of Directors Nomination Form

Please complete and return by September 28, 2007 to:

AHPA Nominating Committee
7245 Arlington Boulevard, Suite 300
Falls Church, VA 22042

Name: _____

Title: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Education:

Professional Experience:

Professional and Community Associations:

Additional (Other) Comments:

AHPA Member Submitting Nomination	
_____ Name (Print)	_____ Signature
_____ Organization	_____ Date
_____ Address	_____ Phone
_____ City/State/Zip	

Acceptance of Nomination
_____ Nominee's Signature
<i>Note: Other indications of nominee acceptance (fax, email, telephone) are permissible.</i>