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President's Message **The End of the Social Contract?** by John Steen

In the 4th Quarter 2004 issue of this newsletter, we published a critique of the Fall 2004 report from the Federal Trade Commission entitled *Improving Health Care: A Dose of Competition*,¹ the executive summary of which concluded with the following statement: "The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace."

In this brief but remarkable statement is contained the federal government's position on health care delivery in America, a position that was introduced within the conservative economic agenda during the Reagan years. "Impersonal" here is tantamount to "unthinking," and that rules out all forms of planning and regulation save those aimed at attempting to secure and support marketplace health care, were there such a thing. And so we are given a policy that is the very negation of all health policies.

Health care delivery is not provided in the "impersonal working of the marketplace." It is provided in local communities by community-oriented providers, it should reflect community values and needs, and it should lead to empowering communities through planning. Additionally, it is provided in a highly regulated and controlled environment that is not consistent with a free market. "Free market competition" is inconsistent with:

- Patient demands for care that are not discretionary;

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The End of the Social Contract?

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- Purchasers' lack of information about prices and costs;
- The assurance of third-party reimbursement;
- Philanthropic subsidization of services;
- Caregivers' control of services received by patients;
- Community input for more appropriate, acceptable, and accountable services;
- Mission-directed and/or status-building institutional health care delivery;
- Legislatively mandated health care services;
- Ensuring the safety and efficacy of health care services and avoiding malpractice;
- Legislatively mandated health insurance benefits;
- "Social safety net" services like Medicare and Medicaid;
- Measures to serve underserved populations and meet unmet needs;
- Priority for public health;
- Equity in a health care system that embodies principles of social justice.

a Mission Statement that had this to say about competition²:

"The longstanding commitment of providers to a community mission which built public trust is being eroded by corporate business practices which generate profits, often without any community benefits. The reliance on market competition for "healthcare reform" is a political and economic experiment which is resulting in dislocations throughout society. The challenge to public policy is to facilitate the development of a responsible marketplace, one in which the sought-after benefits of competition are realized. ...

"To achieve benefit from this process for all residents, it is necessary for legislators to take a more active role in shaping the transformation of the market. Government is obligated to exercise sound stewardship of the public's resources, much of which it controls as the primary payer of services. Healthcare is a social good like safety and education which, in a democratic society, requires intelligent government oversight in order to balance competing needs and priorities."

In my "Policy Perspective" in this issue, the report on specialty hospitals illustrates how competition plays out in delivery systems, emphasizing once more that there are no private (profit-making) solutions to public problems. Yet this is the mantra of the Bush Administration, that government should deed to private investment all functions where there is profit to be made. The excellent publicity that the VHA has gotten for its achievements in solving the quality/cost conundrum must be driving conservatives nuts; may they suffer a fatal case of ideological dissonance.³ What I see as one of the worst applications of their marketplace ideology is the shift of health care information itself from government to the private sector, a threat to states like New York, Pennsylvania, and California that consider information about health care to be a civil right and to planning and regulatory programs everywhere. On February 13, David Brailer, National Coordinator for Health Information Technology, Department of Health and Human Services, said, "We have ensured that the federal government will not build, own or operate the infrastructure of America's health information."⁴

The current Administration's position on an unregulated marketplace is much more than the denial of a health care **system**. It amounts to the denial of a role for government

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In May 1999, the Board of Directors of AHPA adopted

Critical Access Hospital Planning: A Case Study

by Emily R. Mowry

Healthcare Planner, Hart Freeland Roberts, Inc., Brentwood, TN

Budgeting and financial planning for hospital upgrades can be a great source of frustration to hospital administrators, but even more so to the administrators of a critical access hospital (CAH). With a tighter budget and often fewer resources than a large hospital, the typical CAH cannot afford to waste time and money on unnecessary expenses. Does campus master planning qualify as an “unnecessary expense?” No, it is a must do! The master plan works hand-in-hand with the strategic plan and serves as a road map for the future of the hospital.



Hospital Front Entrance

When working with a limited budget, consultant fees can eat into construction costs rather quickly, especially when considering replacing an older, obsolete facility. Too often, the administrator falls for the belief that he/she can hire a firm to draw and build a standard hospital design, which can save both time and money on the front end. But in the long run, does the hospital really save money by

skipping the detailed research and short-cutting the planning process? What are the benefits to pre-architectural hospital planning and why should a CAH administrator allocate funds for this step in the design/construction process?

In January 2006, Hart Freeland Roberts Architects (HFR) in Brentwood, TN was engaged to provide planning and architectural services for Story County Medical Center (SCMC), a CAH in Nevada, IA. The existing facility was built in 1951 and almost all of the mechanical/electrical/plumbing (MEP) systems needed to be upgraded, repaired, or replaced in order for the hospital to meet the regulatory and life/safety requirements. The hospital made excellent progress in expanding their services in spite of the MEP problems. The most recent addition to the campus was a new family practice clinic adjacent to the existing hospital.

Before hiring an architect, administration consulted Healthcare Capital Resources for a financial feasibility study. The results indicated that SCMC could afford to spend approximately \$12 million to renovate and/or replace the existing facility. At an average cost of \$220 per square foot of space, the new hospital could not exceed 38,000 building gross square feet (BGSF). The existing building encompassed over 50,000 BGSF, and administration was hoping to expand their programs and support space.

There were two main questions to answer in this project:

1. Is it more feasible to build a replacement hospital or to renovate the existing facility?
2. If building a replacement hospital proved to be the better option, how could a new hospital be built for under \$12 million?

The master planning process addresses the specific needs and concerns of the individuals in each department as well as the hospital as a whole. The process considers user feedback as the key ingredient to creating a successful master plan. The HFR Healthcare Planning Division (HFR/HPD) typically divides this process into ten basic steps:

1. Distribute questionnaires and clinical data sheets.
2. Conduct a careful situation assessment and review area-wide factors and forces.
3. Conduct two series of interview sessions with directors (one for goals and objectives and one for space needs and concepts).
4. Prepare a departmental space allocation program.
5. Review the master facility plan and building and zoning concepts with leadership and test planning scenarios.
6. Develop site plan alternative concepts.
7. Create total project budget and schedule, and explore phasing options.
8. Present master plan options to hospital leadership.

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Critical Access Hospital Planning

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- 9: Present final budget/phasing options to hospital leadership.
- 10: Present complete master planning study to Board of Directors.

Client input is critical to the master planning process. Before the first set of interviews, HFR/HPD organized questionnaire (Q/A) forms to send out to each departmental director. The Q/A's asked for goals/objectives of the department, space needs, functionality, relationships between different departments, and medical equipment needs/concerns. The Q/A provided a basis for discussion during our first round of interviews with the department heads. Every director was given an opportunity to voice their opinion on what the most important issues were for their department and for the hospital as a whole.

In order to determine if hospital replacement would be more financially feasible than renovation, a thorough engineering analysis was conducted for the existing building. Because the hospital building was 55 years old, most of the mechanical systems were in



Aging Mechanical Systems

the existing facility would be greater than building a brand new campus designed to meet current codes. The disadvantage to building a replacement hospital was that SCMC first had to purchase land. HFR/HPD assisted administration with the due diligence site selection.

obsolete condition and needed to be replaced immediately. Annual maintenance costs were increasing, and the engineering staff was playing catch up. In addition, the building did not meet current codes for ventilation and fire protection. If the hospital chose to renovate, it would be required to upgrade the entire facility to meet current code requirements. The time and cost of repairing

Based on user feedback from the Q/A forms, a room-by-room space program was developed for each department in the existing hospital. Tight space was a common problem in each department, and the initial space program provided additional



Interviews with departmental directors

space required to meet operational standards of the AIA Guidelines. The resulting total project budget exceeded the \$12 million threshold. Some departments would have to remain in the existing building and move over in a later construction phase.

SCMC planned on having Long Term Care (LTC) stay behind in the existing facility, because it took up a large amount of space in the current hospital. Many of the support service functions, for example, Dietary, Maintenance, Materials Management, and Laundry/Housekeeping, could also remain behind in the existing building and support the hospital remotely.

The Physical Therapy Rehabilitation and Cardiac Wellness departments primarily supported the LTC and so were also elected to remain in the existing building. In addition, the SCMC clinic did not include any surgical functions, which indicated that the clinic could be a part of a Medical Office Building (MOB). Construction costs of a new MOB would be significantly less than the construction costs of the hospital. HFR/HPD asked SCMC to consider the idea of hiring a developer to build a new MOB for a reduced cost and lease back the space to the physicians. After several rounds of negotiation, the final space program of the new hospital was approximately 42,000 BGSF including the MOB. When taking into account the reduced construction cost of the MOB, the estimated total cost of construction for a new building was approximately \$11.9 million, slightly under the \$12 million threshold.

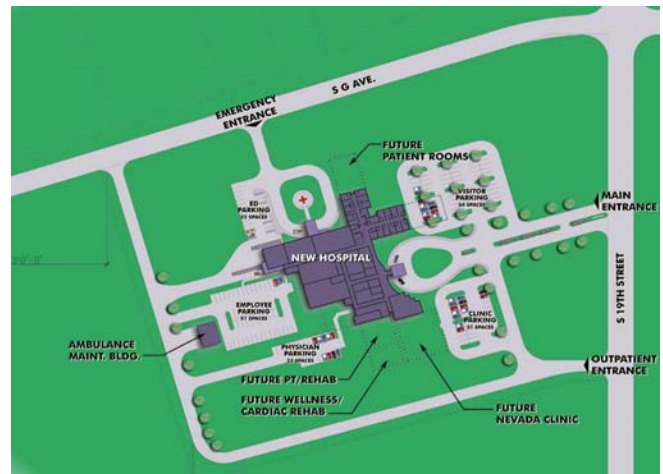
Master planning is a crucial step for all design projects, but especially for projects which involve tight

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Critical Access Hospital Planning

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budgets. In the SCMC project, every square foot had to be accounted for in order to design an affordable-hospital. The space program achieves this objective and serves as a blueprint for the architect. The goal of master planning is to provide the most cost-effective, long-term solution for the hospital and the community it serves. HFR/HPD provided SCMC with a unique solution to allow it to build a new campus in multiple phases. Administration's goal is that the new hospital will increase volumes and revenues, which will allow adequate funds to complete Phase II of construction and bring all hospital functions to the new campus. ♠



New Site Plan

SPACE PROGRAM SUMMARY - Story County Medical Center, Nevada, IA

Department Name	Beds <u>Prop.</u>	Beds <u>Existing</u>	DGSF <u>Proposed</u>	DGSF <u>Existing</u>	Comments
Inpatient Care Units					
Patient Care Unit, Med-Surg/Swing	17	17	8,423	6,196	17 Pvt, 1 isol, 2 monitored, 1 observ.
Patient Care, LTC Attached	[50]	[72]	[19,725]	—	40 Int Care + 10 Memory (dementia)
Sub Total Inpatient Units	17	17	8,423	6,196	CAH License Max. = 25 Acute Care Beds (Expandable for 5 Beds Future)
Diagnosis and Treatment					
Surgery/Recovery			3,028	2,073	
Imaging Suite			2,201	1,056	Move CT From Existing to New Site
Laboratory			1,476	890	
Emergency Department			3,302	1,357	Incl. Paramedics & Dir. EM Svcs
PT/Rehabilitation Services			[3,468]	2,117	Presently Contract
Wellness/Cardiac Rehab			[2,651]	1,420	
Cardiopulmonary/RT			387	200	
Pharmacy			992	592	
Amb Surg/Outpatient Clinic (ASC/OPC)			3,572	2,582	Visiting Physicians, Endoscopy, Stg II
Sub Total D/T Services			14,957	9,705	
Support Services					
Dietary/Dining			[3,905]	6,431	Move in Ph II
Interim Dietary for CAH			672		Use a classroom for dining temporarily
Materials Management			[2,159]	1,665	Move in Ph II
Interim Materials Handling and Staging			300	0	
Central Sterile Processing			444	Incl. W/Surg	
Plant Operations			[1,156]	520	Move in Ph II, Possibly metal building
Housekeeping/Laundry			[2,020]	1,768	Move in Ph II; Housekeeping Closets Ph I
Staff Facilities			[742]	96	Lockers/Toilets, etc.
Sub Total General Support			1,416	10,480	
Administrative and Public					
Admitting/Registration			339	Incl. W/Adm	
Business Office, Billing and Administration			2,353	1,575	Incl. BO/Actg/HR
Social Services			242	125	
Marketing & Development			350	238	
Infection Control/Employee Health			208	Incl. W/ER	
Acupuncture/Kailo			408	100	
Health Information Management (Medical Records)			941	1,098	
Medical Staff Services			512	280	Incl. sleep room
Education/Training			1,238	903	Exist. Incl. Board Room
Main Lobby			1,101	417	
Volunteer/Gift Shop			467	210	Exist. Is Gift Shop only
Religious Functions			178	622	
Sub Total Administrative and Public Spaces			8,337	5,568	
Other Buildings					
Nevada Clinic		Adj. to Hospital	[7,256]	6,061	
Sub Total Other Buildings			0	6,061	
TOTAL DEPARTMENTAL GROSS AREA			33,133	38,010	
MPE Spaces (Acute Care) @ 7.5%			2,485	3,792	Exist. Excl. SF in LTC
Air Handling Rooms/Penthouses			0	UNK	
Acute Care Primary Circulation @ 18%			5,964	9,543	Exist. Excl. SF in LTC
TOTAL BUILDING GROSS AREA REQUIRED			41,582	51,345	
Notes:				9,763	Approximate Gross Differential In Area
1) During interviews staff agreed to leave bracketed items [] on the existing campus.					

Fair Share Health Care

Bentonville to Baltimore in Five Bold Steps

by Dean Montgomery



One of the more intriguing questions roiling state legislatures in 2006 is the debate over health insurance coverage provided by Wal-Mart, Inc. The debate, which pits organized labor and its allies against the nation's largest retailer and likeminded employers, raises fundamental health policy questions.¹ The issue at hand is whether the parsimonious nature of the Wal-Mart health insurance program constitutes an unconscionable, and unacceptable, burden on the public treasury and an unfair corporate practice that disadvantages potential competitors.

Antagonism between unions and nonunion Wal-Mart is longstanding. Health insurance coverage, long a bone of contention, became the focus of critics in 2005 when the Maryland legislature adopted the Fair Share Health Care Act (HB 1284, SB 790), which requires private companies with more than 10,000 employees to spend at least 8% of payroll on employee health benefits or to contribute the difference to Maryland's "fair share health care fund." Robert Ehrlich, Maryland Governor, vetoed the bill. The Maryland General Assembly overrode the veto shortly after reconvening in January.

Encouraged by the Maryland success, and related action in Suffolk County, New York, Wal-Mart critics are pushing for "fair share" health care legislation in more than 30 states during 2006 legislative sessions. As of this writing, legislative proposals have been introduced in 17 states, two of which have failed to pass (Wisconsin and Indiana). The focus is now on proposals in Connecticut, Kansas, Kentucky, Michigan, Minnesota, Mississippi, New Jersey, New York, Washington, West Virginia, and New Hampshire.

As expected, Wal-Mart and its allies acted quickly to challenge the Maryland and Suffolk County legislation. On February 7, 2006, the Retail Industry Leaders Association (RILA) filed lawsuits challenging the Maryland and Suffolk County acts on the grounds that they violate the federal Employee Retirement Income Security Act (ERISA).

Whatever the outcome of the legal wrangling, the facts and practices uncovered by the debate are revealing.

Wal-Mart's health insurance program is by most standards socially retrograde:

- Less than half of Wal-Mart workers have company provided health insurance, with coverage reportedly down from 48% in 2004 to 43% in 2005;
- Wal-Mart health care spending averaged slightly less than \$1,200 per employee between 2003 and 2004, substantially less than half the national average;
- Among large employers, Wal-Mart typically has the largest number and percentage of its employees relying on state Medicaid programs for medical care, ranking number one in the 20 states for which data have been reported; and
- Wal-Mart acknowledges that 5% of its workers are enrolled in Medicaid programs, with other estimates as high as 13%.

Critics argue that this pattern represents a calculated shifting of health insurance costs from Wal-Mart to taxpayers, principally in the form of higher Medicaid program costs. Maryland's "fair share health care" is seen as necessary to eliminate what would otherwise be a state subsidy of Wal-Mart, and similarly minded companies, and to "level the playing field" for competitors, particularly small businesses.

Wal-Mart's response to the criticism, beyond legal action, is revealing not only of its corporate culture and "world view," but also of the problems inherent in relying on voluntary employer-based health insurance coverage. In October 2005, the *New York Times* published a lengthy article, based on an internal memorandum to the Wal-Mart board of directors, outlining the proposed company response to growing public criticism.² Though viewed parochially, the memorandum acknowledged that much of the criticism is based on fact. The memorandum notes that "while critics have not yet harnessed all of these facts, they are successfully exploiting those they do have, suggesting that, when discovered, the others will also be come effective ammunition."³

The memorandum outlines nine "limited-risk" initiatives and five "bold steps" to meet "these challenges." The limited risk actions, which largely entail shifting

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Puerto Rico CON Decision

by Kelli Back, Esq.



On January 9, the Supreme Court granted the motion of American Health Planning Association for leave to file a brief as *amicus curiae* (friend of the court) on behalf of the Commonwealth of Puerto Rico. However, the Supreme Court denied the Commonwealth's request for a writ of certiorari in the case of Perez-Perdomo v. Walgreen, Co. The Supreme Court's denial leaves standing the decision of the First Circuit Court's ruling in the Puerto Rico case concerning Puerto Rico's certificate of need law as it applies to pharmacies.

The First Circuit case was brought by Walgreen Co. and decided in April 2005. Walgreen Co. asserted that Puerto Rico's certificate of need law, as it applied to pharmacies, was invalid because it discriminated against, or excessively burdened, interstate commerce. The First Circuit agreed with Walgreen Co. and held the law was invalid.

The Puerto Rico law required that any pharmacy entering the market after October 24, 1979 obtain a certificate of need. When the law was enacted, over 92 percent of pharmacies operating in Puerto Rico were locally owned. Under the law, if a pharmacy filed a certificate of need application, existing pharmacies located within one mile of the proposed pharmacy site had the right to oppose the granting of a certificate of need. The Secretary almost always issued the certificate if there were no objections, but if there were objections from an existing pharmacy, an administrative hearing was held. After a hearing, the hearing officer forwarded a recommendation to the Secretary of Health for final action. The losing party had the right to ask for reconsideration and also to seek judicial review of the decision.

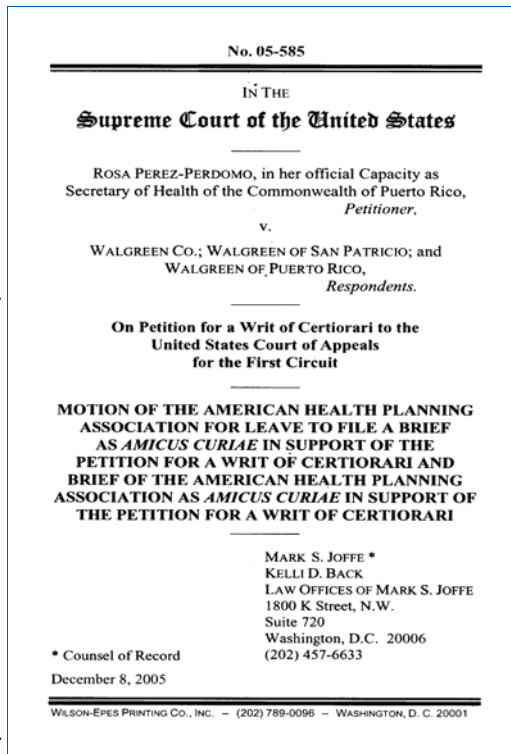
The AHPA filed an amicus brief on behalf of the Commonwealth of Puerto Rico, requesting that the

Supreme Court consider the case. The AHPA was concerned that the First Circuit's decision could be more broadly interpreted to undermine other state certificate of need laws. The AHPA argued that health planning and certificate of need regulation are critically important tools available to states to promote and ensure that there is a reasonable geographic distribution of health care services and resources.

While the Supreme Court let the First Circuit decision stand, health planners can take solace in the fact that the First Circuit decision was narrowly focused on the part of Puerto Rico's certificate of need law concerning pharmacies. The Court noted that Puerto Rico is the only jurisdiction that applies its certificate of need law to pharmacies. Moreover, the Court noted that the Puerto Rico law allowed existing pharmacies to object to a certificate of need request simply because they feared additional competition. The Court concluded that the law had the effect of favoring the existing, local pharmacies and could not be saved because it did not have the

intended effect of causing pharmacies to locate in underserved areas.

AHPA would have preferred that the Supreme Court either reverse the decision or adopt language recognizing the value of state certificate of need laws and more explicitly contrasting Puerto Rico's law from those adopted by most states. However, based on the First Circuit Court's narrow holding, it would still be difficult to use the holding in the Puerto Rico case in order to argue for the invalidation of meaningful certificate of need laws in other states. Thus, the Supreme Court's denial of cert may not have any practical affect on the validity of most state certificate of need laws. ♦



POLICY PERSPECTIVE

By John Steen

Specialty Hospitals

The issue of specialty hospitals is becoming a perennial, not only because it so clearly differentiates the CON states from those without CON, but because it reveals in microcosm many of the current tensions in health care policy. The most critical tension is that between competition and planning/regulation, but a host of other issues are also implicit within it, issues that have increasingly been the subject of policy research over the last two years.¹

Two of these underlying issues are the low payment for most Medicaid patients and the lack of payment for uninsured patients, which together create strong incentives for specialty hospitals and community hospitals alike to attract well-paying patients and avoid others. Stuart Guterman, examining this dynamic, concludes, "Above all, the lack of explicit financing of the broader (and unprofitable) missions of health care facilities is a major failure, with implications far beyond the question of whether or not specialty hospitals should be allowed."²

The Center for Studying Health System Change has been following these issues closely. In a new report,³ it illuminates the nature of the competition these hospitals pose. The report bases its findings on circumstances in Indianapolis, Little Rock, and Phoenix, three sites where there has been significant specialty hospital development. Among its findings:

- Some purchasers believe that referring physicians, especially those with a financial interest in the specialty hospital, increase volume by inducing patient demand for elective procedures. The higher volume more than offsets the savings achieved from lower prices from competition, leading to increased aggregate costs.
- Some health plans and employers believe that physicians referred relatively easy cases to specialty hospitals and more complex patients to general hospitals, whether out of quality concerns or financial considerations.
- Although there was some evidence of increased price competition, respondents observed that the more important outcome was the perceived need for general hospitals to compete aggressively with

the new physician-owned specialty hospitals by developing similar dedicated centers, as distinct hospitals-within-hospitals or freestanding facilities. Moreover, purchasers believe specialty hospitals have unfair advantages that create an unlevel playing field for hospital competition, and some suggested that certificate-of-need regulations be used to limit the growth of specialty hospitals.

- "Although respondents were not specifically asked about possible policy approaches to address their perceptions about nonproductive competition stimulated in part by specialty hospitals, some employers and health plans suggested that increased government regulation to limit specialty hospital growth might be desirable. In Indianapolis and Little Rock, respondents suggested that certificate-of-need regulation might be needed to restrict the growth of specialty hospitals. Indeed, in two other HSC sites that have not seen physician-owned specialty hospitals, Miami and northern New Jersey, health plan respondents referred approvingly to CON restrictions on specialty hospitals in their states."

Thus, the report judges that specialty hospitals are contributing to a medical arms race that is driving up costs without demonstrating clear quality advantages. The findings again confirm that even a competitive health care system does not function like most other sectors of the economy. The report concludes that

"Up until now, specialty hospitals have not had to outperform general hospitals on costs or quality because specialty hospitals have had inherent advantages from pricing distortions, physician self-referral, favorable case-mix, and lack of an uncompensated care burden. Eliminating these advantages would provide a more meaningful test of whether there is an important role for specialty hospitals as focused factories, as some have advocated. Some believe that permanent barriers to entry of specialty hospitals through targeted CON restrictions, as some states have adopted, should await such a test, so that a better assessment could be made. But others are skeptical about policy makers' ability – or commitment – to create the conditions for a true level playing field."

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Angioplasty and Open Heart Surgery

Across the country, the number of open-heart surgeries is declining and angioplasties are increasing. For example, the total number of bypasses in New Jersey declined by 16.6 percent between 2000 and 2004 (n=8009), and the number of angioplasty-stent procedures to open clogged heart arteries rose 66 percent (n=25,520). Bypass surgeries in Southeastern Pennsylvania fell by 35 percent between 1997 and 2004 (n=4348), while angioplasty-stent procedures soared by 49 percent in the same period (n=12,777), showing that three times as many angioplasties as bypass surgeries were performed in area hospitals in 2004. National guidelines call for a minimum of 100 to 125 open-heart surgeries per hospital (and ideally many more), and 200 angioplasties per hospital to maintain quality. In New Jersey, the Department of Health requires that hospitals do a minimum of 350 open-heart surgeries. If they fall short of that number, to maintain a program, they must demonstrate outcomes that are in line with the state average. In Pennsylvania, where there is no such condition for licensure, the latest report from the Pennsylvania Health Care Cost Containment Council (PHC4) shows that more than half of the 60 hospitals with open-heart programs fell below the 350 threshold encoded in New Jersey. The average number of cases per hospital decreased from 390 in 2003 to 376 in 2004, a decline of 3.6 percent. The average number of open-heart surgeries performed per surgeon has remained relatively constant since 2002 at approximately 130 cases.

The impact of Pennsylvania's loss of its CON program at the end of 1996 is evident in Philadelphia and its four suburban Pennsylvania counties (with 3.9 million people), where 22 hospitals have open-heart programs. In New Jersey, with a population of 8.5 million, just 17 hospitals performed bypasses in 2003.

PHC4's first report in 1991 showed a mortality rate of 4.90 percent for the state's open-heart surgery programs. By 2003, that rate had fallen to 2.04 percent in-hospital mortality (2.36 percent thirty-day mortality), and in 2004, to 1.98 percent in-hospital mortality (2.31 percent thirty-day mortality). These rates are still comparable to New Jersey's (2.33 percent thirty-day mortality in 2003). The agency's latest report for 2004 reveals that the area in which the state's 60 bypass hospitals most need to improve in order to further reduce their mortality rates is in nosocomial infections. By-

pass patients with hospital-acquired infections (2.6 percent) had a death rate of 12.6 percent compared with 1.7 percent for those without that complication, the report shows. The infected patients had hospital stays of nearly 23 days on average compared with less than seven days for those with no infection. PHC4 data suggests that hospital-acquired infections were likely underreported for 2004.

A just-completed study at Cedars-Sinai Medical Center in Los Angeles demonstrated that treatment of the most serious form of heart disease (severe stenosis of the left main coronary artery) with angioplasty and drug-eluting stents resulted in outcomes at least equivalent to bypass surgery.

It may now be seen by state regulators as appropriate to have a moratorium on new programs in order to evaluate the impact of these trends and recently approved programs on overall service quality and access.

Trauma Centers

Trauma centers are the subject of a nationwide study conducted by researchers at the Johns Hopkins Bloomberg School of Public Health and the University of Washington School of Medicine. The study⁴ analyzes the outcomes of 5,190 adult trauma patients who received treatment between July 2001 and November 2002 at 18 level 1 trauma centers (the highest level of care) and 51 non-trauma centers in 14 states. The researchers also analyzed the characteristics of each hospital, such as the number of patients treated and types of specialty services available. After adjusting for factors such as severity of injury, patient age and pre-existing medical conditions, the researchers found a 25 percent overall decrease in the risk of death following care in a trauma center compared to receiving care at a non-trauma center. The adjusted in-hospital death rate was 7.6 percent for patients treated at trauma centers compared to 9.5 percent for patients treated at non-trauma facilities (relative risk, 0.80; 95 percent confidence interval, 0.66 to 0.98). The mortality rate one year following the injury was 10.4 percent for patients at trauma centers compared to 13.8 percent for patients at non-trauma centers (relative risk, 0.75; 95 percent confidence interval, 0.60 to 0.95). The effects of treatment at a trauma center varied according to the severity of injury, with evidence to suggest that differences in mortality rates were primarily confined to patients with more severe injuries.

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The End of the Social Contract?

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Itself, and of the very concept of government on which our founding fathers established this nation (see box). And government functions that are supportive of communities and social values are compromised in order to condemn them as dysfunctional (post-Katrina New Orleans is a case in point), thereby preparing the way for their elimination.

For a half-century, we had traditional indemnity insurance that supported our use of health care, a threat the industry labeled a “moral hazard.” From the supply side, the industry introduced “managed competition” to reduce service utilization. The newest trend reduces utilization from the demand side by making it unaffordable to the consumer. Known as “consumer-directed health care” (or “consumer-driven health care”), it is being promoted as the new market-based solution to cost inflation. Consumer-directed care refers to health plans in which employees have personal health accounts from which they pay medical expenses directly. It threatens important societal values – in particular, the goal of establishing relationships between patients and clinical professionals based on trust.⁵

The Administration is spinning its health savings accounts as introducing competition into the pricing of health care, the idea being that once patients are forced to pay more costs out of pocket, they will begin to comparison shop and request quality data, eventually driving down the cost of health care. But the information consumers need to manage these accounts most effectively is how much their out-of-pocket costs will be for a particular service and not how much, for example, a hospital charges for a particular service. Here we have an artifact of insurance marketing, not an indicator of health system cost, and it’s an artifact designed to promote a race-to-the-bottom in health insurance coverage while getting consumers to think they are saving money. As with almost all of the Administration’s health policy initiatives, it is hard to tell how much they are driven by incompetence, and how much by meanness.

The justification for having any government at all is to have a way of satisfying needs that cannot be satisfied adequately by individuals. The leaders we elect, and the people they employ, are the stewards whose responsibility it is to meet our needs. What we have

here is the perversion of that contract, where our burdens are magnified and returned to us at the very time when we are least able to handle them. As George Soros says, “Markets are designed to facilitate the free

*Thomas Hobbes (1588-1679), traveling in Europe to meet with scientists and to study different forms of government, became interested in why people allowed themselves to be ruled and what would be the best form of government for England. In *Leviathan*, he argued that people were naturally wicked and could not be trusted to govern and that an absolute monarchy - a government that gave all power to a king or queen – was best. He came to believe that giving power to the individual would create a dangerous situation that would start a "war of every man against every man" and make "the life of man, solitary, poor, nasty, brutish, and short," identifying three basic causes: competition, diffidence, and glory. The only escape from danger is by entering into contracts with each other – mutually beneficial agreements to surrender our individual interests in order to achieve the advantages of security that only a social existence can provide.*

Hobbes provides us with a useful insight into better understanding the promotion of unfettered competition when he quotes Cicero, who approved the Roman practice in criminal cases of asking "cui bono; that is to say, what profit, honour, or other contentment the accused obtained or expected by the fact. For amongst presumptions, there is none that so evidently declareth the author as doth the benefit of the action."

exchange of goods and services among willing participants, but are not capable, on their own, of taking care of collective needs. Nor are they competent to ensure social justice. These ‘public goods’ can only be provided by a political process.”⁶

Let us not miss the greatest insult in this love of market competition. When we promote competition at the expense of all other motivation, we depreciate the interest we have in compassion, thereby depreciating

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Deficit Reduction & Medical Imaging Spending

Special interest imaging groups are not pleased with the Medicare “cuts” contained in the Deficit Reduction Act of 2005 (S. 1932), which became law on February 8, 2006. About a third (\$2.8 B) of the \$6.0 billion in projected Medicare savings is expected to come from reduced payments for “in office” imaging procedures. The reductions come largely from lower payments for multiple same day imaging procedures on “contiguous” body parts and from capping “technical component” payments for physician office procedures at the hospital outpatient department level.

These changes, should they withstand the inevitable onslaught from the groups affected, have the potential to affect both the rate of growth in some imaging procedures, notably MRI, CT, PET and PET-CT, and where those services are provided. U S Oncology, a big player in the PET and PET-CT market, complains that these changes may “drive patients back into the hospital setting,” “degrade quality,” and “severely impact cancer care access” by 2007.¹

Other organizations have equally dire predictions. Strategic Outpatient Services, a New Jersey provider of imaging services, argues that these changes would result in revenue decreases of between 20% and 40% and that “20% to 25% of existing outpatient diagnostic imaging centers will go bankrupt during 2007.”²

These assertions are exaggerated at best, but they do suggest that the changes in Medicare reimbursement could affect service demand and delivery patterns that are of interest to planners. At minimum, it should be instructive to follow the action of U S Oncology, the National Coalition for Quality Diagnostic Imaging Services (NCQDIS) and the American College of Radiology and they fight for their accustomed privileged place athwart the Medicare revenue stream.

¹ See www.legislink.com

² “Impact of Pending Medicare Cuts . . .” Strategic Outpatient Services, River Edge, New Jersey. www.strategicoutpatient.com

The End of the Social Contract?

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our own humanity. That our collective humanity is already depreciated is evident in daily news reports, e.g., a Valentine’s Day report in The Washington Post on health program cuts in the Administration’s proposed budget, including elimination of federal support for inner-city Indian health clinics, defibrillators in rural areas, an educational campaign about Alzheimer’s disease and centers for traumatic brain injuries.

¹ A fuller critique of this document is accessible online at: <http://www.ahpanet.org/images/AHPAcritiqueFTC.pdf>.

² To see all of our Board-adopted policy statements, go to: <http://www.ahpanet.org/ahpolicies.html>. And for a cogent discussion of the illogic of reliance on market forces to improve the efficiency of health systems, see “Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning,” by Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson and Robert E. Hurley, in *Health Affairs*, Vol 23, Issue 2 (March/April 2004), pp. 8-21, accessible at <http://content.healthaffairs.org/cgi/content/abstract/23/2/8>.

³ See my article at http://www.ahpanet.org/Health_policies.html#Universal2.

⁴ Address to the Healthcare Information and Management Systems Society (HIMSS). See <http://www.healthimaging.com/content/view/3839/85/>.

⁵ See, “Which Way For Competition? None of the Above,” by Robert A. Berenson, *Health Affairs*, Vol. 24, Issue 6 (Nov/Dec 2005), 1536-1542. Online at: <http://content.healthaffairs.org/cgi/content/abstract/24/6/1536>.

⁶ *The Bubble of American Supremacy*, 2003.

⁷ “Bush Budget Would Cut Popular Health Programs”, By Ceci Connolly, Washington Post Staff Writer, February 14, 2006; A03. <http://www.washingtonpost.com/wp-dyn/content/article/2006/02/13/AR2006021302065.html>

Policy Perspective

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“Hospitals have difficulty justifying the expense of maintaining trauma centers without strong evidence of their effectiveness. Now we have conclusive data to show that trauma care is effective,” said the study’s lead author, Ellen J. MacKenzie, PhD, professor and chair of the Department of Health Policy and Management at the Bloomberg School of Public Health. “The findings of this study argue strongly for continued efforts at regionalizing trauma care at the state and local levels to assure that patients who suffer serious injuries get to a trauma center where they are afforded the best possible care.”

¹ For an introduction to this subject, see my article, “Boutique Hospitals: Competition or Exploitation?” from the 2nd Quarter 2004 issue of *Health Planning TODAY*, online at <http://www.ahpanet.org/images/AHPAspechospArticle.pdf>.

² “Specialty Hospitals: A Problem or a Symptom?,” *Health Affairs*, January/February 2006. The article is online at <http://content.healthaffairs.org/cgi/content/full/25/1/95?ijkey= oMTsWRDMc5BI&keytype=ref&siteid=healthaff>.

³ “Do Specialty Hospitals Promote Price Competition?” by Robert A. Berenson, Gloria J. Bazzoli, and Melanie Au (January 2006). To view the report: <http://www.hschange.org/CONTENT/816/>.

⁴ “A National Evaluation of the Effect of Trauma Center Care on Mortality,” *New England Journal of Medicine*, January 26, 2006. Funding for the study was provided by the Centers for Disease Control and Prevention’s National Center for Injury Prevention and Control and the National Institutes of Health’s National Institute on Aging. To view it online: <http://content.nejm.org/cgi/content/short/354/4/366>.

Fair Share Health Care

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shifting money spent on one benefit (e.g., life insurance, spousal coverage) to another (e.g., earlier coverage of part-time employees), are designed for maximum public relations benefit and minimum internal disruption, and to ensure there is no net increase in cost. In the language of the memorandum, “these nine initiatives require little or no trade-off between cost, employee satisfaction, and public reputation.”

Bold steps are another matter. They “will require more explicit trade-offs between cost, Associate [employee] satisfaction, and public reputation.”⁴ Recommended action entails:

- Moving employees to “progressively designed” consumer-driven health plans, i.e., health savings accounts;
- “Restructuring” the retirement program;
- Attracting a healthier, more productive work force;
- Making “strategic investments” in “health care offering so it can better withstand external scrutiny,”
- Improving communication of the benefits offering to get more credit for what is provided and “work to shape the outcomes of state and national health care reform efforts.”

Wal-Mart understands that health savings accounts (HSAs) are not popular among workers, but notes that strong opposition is limited to about 10% of the workforce and that other corporate “consumer-driven plans,” including the “ever-progressive Whole Foods,” provide Wal-Mart with “political cover.” Equally keen political calculus is applied to the questions of retirement program restructuring and attracting a “healthier and more productive workforce.” The overall Wal-Mart contribution to its 401(K) program would be reduced by 25%, from 4% to 3% of salaries, on the grounds that, given the focus on health care and that retirement is a “low importance” benefit for company workers, “the retirement program seems to be the wrong place for over investment.”

The memorandum is wonderfully direct with regard to what has to be done to affect health care costs meaningfully. The syllogism goes: a healthier workforce will result in lower health care costs; it is “far easier” to attract and retain healthier workers than to accommodate or change the behavior of existing workers; therefore the focus should be to dissuade “unhealthy people” from coming to work for Wal-Mart. How do you dissuade? Well, consumer-driven health care plans are a

start because “these plans are more attractive to healthier Associates.” Another tactic is to redesign jobs to require more physical effort on the part of all workers, presumably dissuading those with physical limitations from applying.

Tinkering with the benefits package is intended to reframe the arguments of critics, while reducing costs. The arguments proposed are designed to keep benefits spending “at or below” current levels, while offering a more attractive benefits package to “healthy Associates” and better position Wal-Mart to fight its critics.

Whatever one thinks of the Wal-Mart *zeitgeist*, it is not exceptional. It is evident that any amount of criticism will yield little, if any, net gain, unless specific action is legally mandated. More importantly, it illustrates the inefficiency, the ineffectiveness, and ultimately the futility of relying on employer-based health insurance as the mechanism by which medical care is made available to the broader populace. This has always been true, but is blindingly so in an era shaped by the interrelated forces of globalization, unbridled capitalism, technological dislocation, and social atomization.

Rather than argue with the Wal-Marts of the world about a social conscience they may never have had or do not believe they can afford, perhaps they should be left to wreak commercial havoc from Bentonville to Beijing as best they can. The buccaneer life, though exhilarating, often is short. Moreover, if forced to increase meaningfully their benefits package, Wal-Mart may feel compelled to reclassify their “Associates” as mere employees. The psychic pain is sure to outweigh any gain.

¹ For the unions involved, contending views, and the debate see: www.wakeupwalmart.com ; www.walmartwatch.com ; and www.walmartfacts.com .

² Steven Greenhouse and Michale Barbaro, “Wal-Mart Memo Suggests Ways to Cut Employee Benefits,” *The New York Times*, October 26, 2005.

³ The memorandum laments that critics hold Wal-Mart to a “large company” standard rather than to the presumably less demanding “retailer standard”. Susan Chambers, *Memorandum to the Board of Directors: Supplemental Benefits Documentation, Board of Directors Retreat FY 06*, p. 8. Unless otherwise indicated, language in quotation marks is taken directly from the *Memorandum*, a copy of which is available at the websites listed in note one.

⁴ *Ibid*, p. 2. ♦

