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3rd Quarter, 2006

Vol. XXVIII, No. 3

# Health Planning

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the newsletter of the  
American Health Planning Association

## *President's Message*

### **Asking the Right Questions**

by John Steen

My temperament is that of an idealist and my education prepared me to teach moral philosophy, so it shows in how I now write on health policy. It leads me to want to address the categorical shortcomings I always find in the otherwise growing body of serious writing on the health care system this nation deserves, and to do so the way I used to teach philosophy in graduate school.

To teach is to show others how to think clearly, and that can't begin unless we have questions in mind. So what I'm asking is, "What questions should guide us in determining how to describe the health care system that would provide optimal benefits for the American people?" To answer that we must have a context in which we see the whole picture: Our nation, its people, and our values.

With what tools do we proceed? Clear thinking requires that logic governs thinking driven by moral values, for we must begin with the insight that we are raising major moral questions. And beginning with a vision, we must proceed from the general

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## Health Planning Today

*an American Health Planning Association publication*

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**Contributions:** Articles and other contributions are welcome. Submissions are due quarterly: March 1, June 1, September 1, and December 1. Articles should be short, preferably limited to one page of text. The editor reserves the right to edit any article or other submission as necessary to permit publication. Electronic submissions are preferred. Articles and other information should be sent to:

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### Asking the Right Questions

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to the particular, from our goals for our society to the means for reaching them – the health care system we would design. It will save time if we list our questions simply as “who, what, why, and how,” though logic requires that we address them in a somewhat different order. The context for our thinking will be developed in considering how to answer them:

- **What?** Good health. What are the conditions that produce good health in a society?
- **Why?** Because health is fundamental to enjoyment of the “life, liberty, and the pursuit of happiness” that we hold to be our birthright. Compassion for our fellow man and concern for our communities as places supportive of the flourishing of those qualities implies that health is to be seen as an important national goal. This imperative can be expressed by promoting health as a human right.
- **How?** By maximizing the ability of individuals, families, and communities to define and

realize their own well-being.

- **Who?** It will require the participation of everyone to realize these benefits.

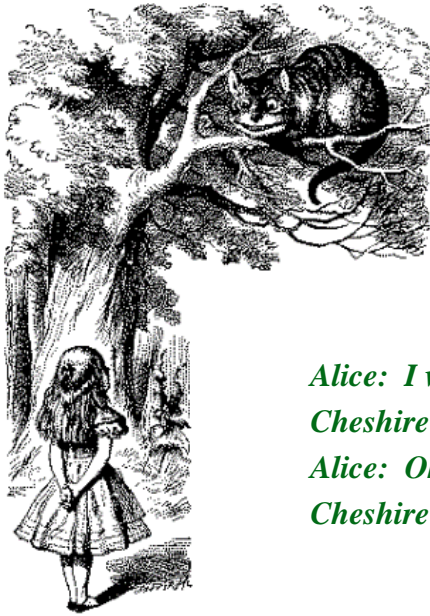
These are questions that can be addressed by national health planning, the sort of questions that were raised by the World Health Organization in producing its *World Health Report 2000*. The ultimate questions for a discipline must be answered by principles from another, more fundamental one. Commentators usually refer to the roles played by competition and regulation, business and government, but these are political and economic policy questions that need to be addressed in the same way as our questions about what kind of a health care system we ought to have. Because ours are moral questions, they must be answered by each and every one of us, and to do so effectively, we need *education in clear thinking*.

Americans need to relearn responsibility for our own development and the role of education in empowering that process. With better education comes more personal discipline and greater participation in public life. Only then can the universal aims of public health be realized through a society that holds education and government in such high esteem. There are many excellent articles on improving health in our society in our most informative newspapers, magazines, and journals, not to mention books, but these are all written by and for those well-educated individuals we’ve come to see as an elite. The distances between people need to be reduced by closing the economic, social, and political divides that we’ve allowed to develop through a deficiency of caring.

Of paramount importance is how these values are perceived. The business sector fully understands W. I. Thomas’s principle that “if men define situations as real, they are real in their consequences,” and they spend enormous sums ensuring that we see their products in the best light and remain blind to their faults. To counter this, we must all teach each other to see more clearly what we’ve been missing – the big picture. For a society as for an individual, its ultimate expression is the face it puts on itself.

More than any other nation, throughout our history we have revered the freedom and the initiative to maximize profits, and we have celebrated those who succeed. But having succeeded, the best of them acknowledged their debt to the nation that offered such opportunities. Rather than setting them apart, wealth opened their eyes to their connectedness to all those who helped to earn it for them.

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**“Prediction is very difficult, especially if it is about the future” .....Nils Bohr**

**An Invitation . . . A Challenge**

*Alice: I was just wondering if you could help me find my way.*

*Cheshire Cat: Well that depends on where you want to get to.*

*Alice: Oh, it really doesn't matter, as long as ...*

*Cheshire Cat: Then it really doesn't matter which way you go.*

The chart on the following page shows acute-care hospital average daily census (ADC) in a large, rapidly growing community for the years 1978 through 2004. The civilian population roughly doubled during this period, increasing from about 1.1 million in 1978 to about 2.0 million in 2004. It is not a gated community, but there is relatively little net migration for hospital care. The acute care hospital discharge rate has ranged between 66 and 69 discharges per 1,000 persons.

Though specific to one community and a bit of a leading indicator, the pattern shown is not greatly dissimilar to the national pattern over the last 20 to 25 years. Two of the lines on the chart, the “three month moving average” and the “regression line,” are calculated. The others are close approximations of trend lines that would result from calculations using data from the periods covered by each line. Horizontal lines represent plots of approximate averages.

Based on these data, and any other information or considerations you may wish to bring to bear, how would you respond to these questions:

- Assuming a stable discharge rate, what explains the “v” shaped pattern between 1993 and 1999?
- Is another significant change in direction likely? If so, when? And why?
- What logical inferences, if any, can be drawn about the Wonderland community these data describe?
- Assuming the data are accurate, what are the most likely explanations for the pattern shown?
- Given these data, what method or combination of methods would be best to project the ADC 2015?

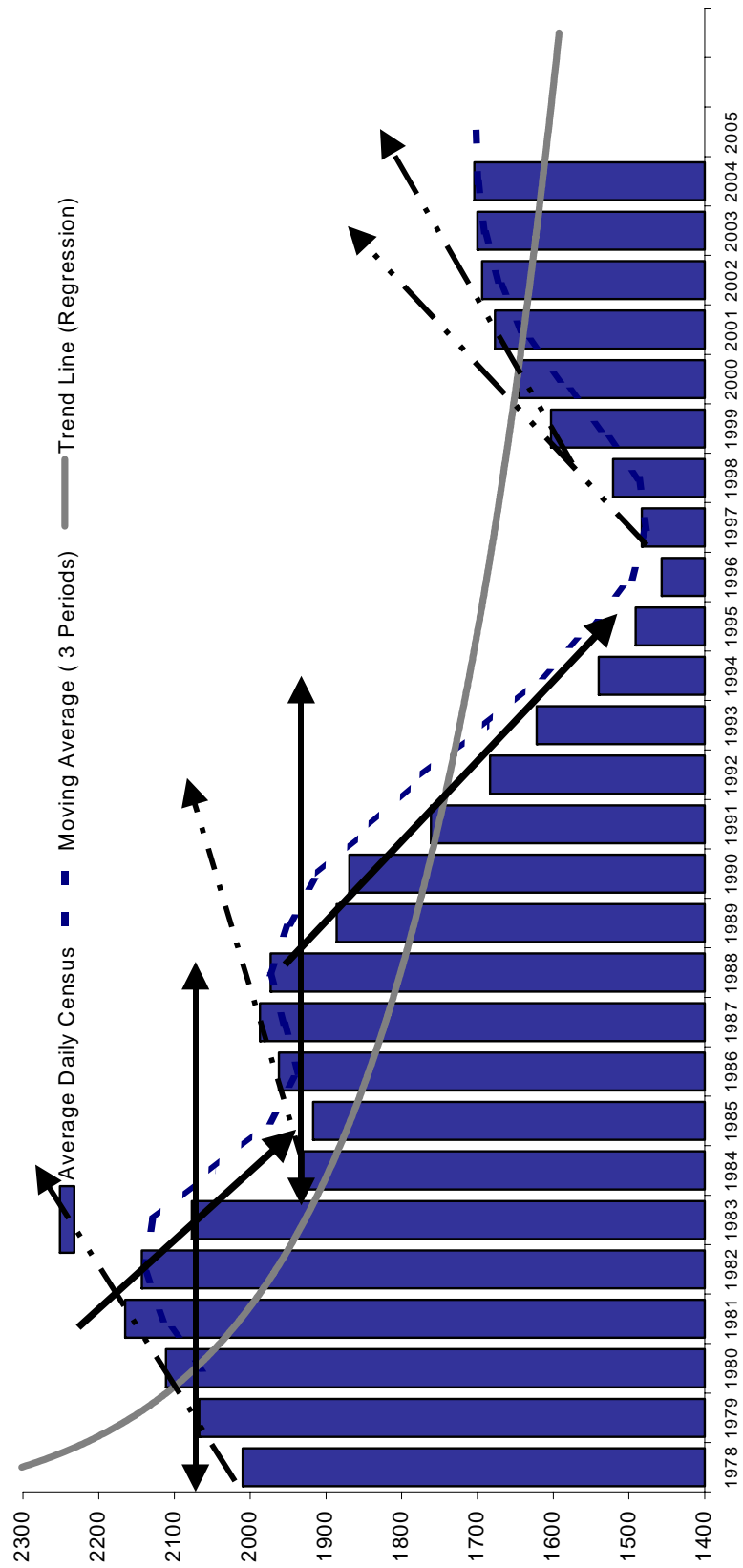
Your comments and observations are welcome. Send your thoughts to:

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or to: The Editor  
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Also welcome: Any similarly provocative array of data of utilization of some health care service.

**Community X Hospital ADC  
Average Daily Census (Inpatient Days)  
1978 - 2004**



# A Brief History of Report Cards

by Jon Steen

Florence Nightingale's historic breakthrough achievement during the Crimean War -- pioneering the modern administrative role of nurse superintendent with measurable outcomes supported by irrefutable data -- first established the principle of accountability for the results of medical practice. However, it wasn't until 1910 when a physician, Ernest Amory Codman, M.D., advanced what he called the "end result idea ... merely the common-sense notion that every hospital should follow every patient it treats long enough to determine whether or not the treatment has been successful, and then to inquire, if not, why not, with a view to preventing a similar failure in the future," that the principle became institutionalized.

Reports on hospital processes and outcomes have been produced for private consumption since the 1980s. Among the best known are those of the Maryland Quality Indicator Project, which began among Maryland hospitals in 1985, and Cleveland Health Quality Choice, which issued its first report in 1993. But the production of public, statewide reports in a sustained effort is a function of state governments.

In 1991, New York's *Newsday* published an article that listed the names and mortality records of doctors doing heart bypasses throughout New York State. The information came from a New York State Health Department report never intended for public information. The State's intention was to improve the outcomes of all its open-heart surgery programs and surgeons by sharing information with all of them on their performance. The results of doing so were so positive that Pennsylvania, California, and New Jersey soon followed suit.

It's been over fifteen years since that process of public reporting began, and researchers at the Harvard School of Public Health recently reported on its continued efficacy in influencing professional practice in the state.<sup>1</sup> They found that more than 20 percent of surgeons who received scores in the lowest quarter for New York State stopped performing cardiac-bypass surgery within two years of the report's release, compared with 7 percent of surgeons who received grades in the middle, and just 5 percent of physicians who received grades in the top quarter. Some surgeons

who stopped practicing cited continual pressure from colleagues and department chairs to improve as their reason for their decisions. As for outcomes, the researchers found that patients who picked a top-performing hospital or surgeon from the latest available report (33 hospitals, 168 surgeons) had approximately half the chance of dying as did those who picked a hospital or surgeon from the bottom quartile, but those outcomes did not have a corresponding effect on market share.

In New York State's first report, issued in 1990, the risk-adjusted mortality rate for 1989 was 4.2 percent. In its very next report just two years later, the rate for 1992 had dropped to 2.5 percent, a 41 percent reduction in three years. This occurred even though the number of coronary artery bypass grafts (CABGs) rose to 16,028 in 1992 from 13,946 in 1990, and despite a pool of patients in 1992 with higher pre-operative risk scores than their 1990 counterparts. So marked an improvement captured national attention, an improvement the state's health commissioner attributed to use of the Department of Health's reports by the state's 31 CABG hospitals for quality improvement efforts. In the latest report, providing 2003 data for 36 hospitals, that rate had declined to 1.61 percent. The New York State Department of Health uses logistic regression to calculate risk adjustment considering approximately 40 risk factors, and coronary angioplasty is included. The report cards are available free from the New York State Department of Health by calling an 800 number or by going to the state's website.



Pennsylvania has been issuing hospital performance reports (providing information on 49 conditions and procedures) since 1989, and CABG reports on hospitals and surgeons since 1992. The state passed a law in 1986 that specifies that cost data may not be disclosed unless accompanied by data on quality. This legislation also established the Pennsylvania Health Care Cost Containment Council (PHC4). Its reports are by far the most comprehensive ever issued, covering volume, mortality, length-of-stay, and other outcome information for 75 diagnostic groups at all 187 hospitals, with more-detailed reports on coronary-

## A Brief History of Report Cards

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bypass surgery at 62 licensed hospitals, heart-attack care, and Cesarean-section rates.

California passed a law in 1991 under which statewide hospital outcomes data were collected by the state's Office of Statewide Health Planning and Development (OSHPD) and released in 1993. In 1995, it established a voluntary program designed to collect and report CABG mortality data for participating California hospitals. This represented a public-private partnership between the OSHPD and the Pacific Business Group on Health, a statewide coalition of purchasers of care. The first CABG report appeared in 2001, based on 1997-98 data. The voluntary program was replaced by a mandatory program that began collecting CABG data in 2003 from all hospital cardiac units and now reports risk-adjusted outcomes annually at the hospital level and bi-annually at the surgeon level. The reports provide volume and mortality information on coronary-bypass surgery for 79 of 118 hospitals that perform it, and mortality information for 398 of 400 hospitals admitting heart-attack patients.

Florida's Agency for Health Care Administration issued a statewide report in 1994 on outcomes from 213 acute care hospitals, using 1992 data. New Jersey issued its first cardiac surgery report on hospitals and surgeons in 1997, and it also issues reports on HMO performance. Its latest report provides volume and mortality information for 16 hospitals. In 2003, the Vermont legislature passed legislation requiring Vermont hospitals to publish annual hospital community reports containing information about quality, patient safety, financial health, costs for services, and other hospital characteristics. This includes volume and mortality results by individual hospital for seven procedures including CABG during 2002, 2003 and 2004. Texas issues volume and mortality information for 25 procedures, and Virginia provides volume and mortality rates for open-heart surgery, invasive cardiology, and medical cardiology.



Massachusetts has reported on CABG and angioplasty for six years, but it has never released data on individual surgeons. The state's most recently reported mortality rate for CABG (2003 data) was 2.25 percent. Officials are now considering whether to issue reports for individual surgeons.

Ohio has just passed a law requiring all of its hospitals to report to the Ohio Department of Health information on dozens of scientifically based quality indicators. Hospitals will have to report the costs of the top 60 inpatient and outpatient procedures they perform. The new law takes effect in November, but it will take the Ohio Department of Health until the middle of next year to create the database and to provide access on its Web site.

The real significance of this kind of state reporting is in its ability to further two fundamental goals of health planning: measurement of quality and education of the public about health care delivery. States can be seen as acting upon a principle grounded in medical ethics, that public access to data is a civil right. They have operationalized a consumer entitlement to information and a provider imperative to improve through collaborative peer review processes. It is the certificate of need process that regionalizes specialized medical procedures, enabling the development of proficiency, and report cards measure and report the results of that process.<sup>2</sup> With optimal regionalization, one of the goals of health planning can be achieved – uniformly superior outcomes in *all* hospitals. This was achieved for CABG surgery in New York State a decade ago.<sup>3</sup>

As shown by the *Health Affairs* study, report cards assist in this process by encouraging continuous quality improvement and even reshaping professional practice patterns. They were instrumental in causing low-volume hospitals in New York State to voluntarily abandon open-heart surgery in favor of new referral alignments with higher-volume hospitals. A comparison of New York State and Massachusetts, each of which has effectively regionalized CABG surgery for decades, revealed that it was the progress in the practice of cardiac surgeons that was principally responsible for their superior outcomes, and regionalization greatly assisted in that process. But Massachusetts, without “report cards,” has never achieved quite as low a risk-adjusted mortality rate as has New York.<sup>4</sup> There is conflicting information concerning whether report cards stimulate “gaming” to show better outcomes at the expense of the sickest patients, but this can be prevented if the cards are based on all patients with an illness, not those receiving a procedure.

The role that state report cards play in good public policy is that of stimulating improvement in health

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# POLICY PERSPECTIVE

by John Steen

## Specialty Hospitals

In a study published online by *Health Affairs* on July 26, 2006<sup>1</sup>, the researchers found that specialty hospitals that focus on such areas as heart disease and cancer can lead to increased health care costs in markets in which they compete with traditional full-service facilities. Although specialty hospitals have increased competition in many markets, they compete on services rather than prices, so they do not lead to reduced health care costs in most cases. The study confirms that, much as in the pre-managed care era of the 1980s, contrary to "... mainstream economic theory, hospitals in more competitive environments had higher costs per case and per day than those in less competitive environments, when other factors were controlled for." Full-service hospitals to date have compensated for the loss of market share to specialty facilities "... by raising prices for profitable specialty-lines."

Furthermore, increased availability of certain services, in combination with marketing to consumers, might increase demand for medically unnecessary procedures. The study authors found that "it seems clear that the intent of the Stark law limitations on physician self-referral has not been achieved, largely because physicians have figured out how to take advantage of the broad exception in the law for services provided by self-referral that occurs within their own practices or for services they personally provide."

There are implications for erosion of quality here too.

"Theoretically, service-line competition could cause quality erosions if a continued or even increased dispersion of cases among many competing facilities compromises the volume-outcome relationship that exists for many technologically oriented services, such as complex surgery.<sup>2</sup> In addition, quality could be compromised if more patients receive inappropriate services that a service-line provider is in business to promote."

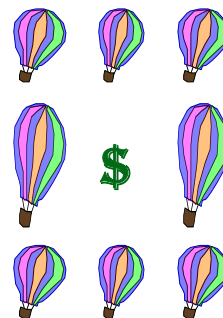
Not all of these specialty-service lines are freestanding specialty hospitals; more are centers within a general hospital and include physician specialists and an increasing number are physician-owned ambulatory spe-

cialty facilities. The authors foresee these changes as creating growing problems for hospitals in maintaining control of their financial integrity.

"Hospitals still have sufficient control over many profitable service lines and continued contracting leverage with managed care plans, such that rate increases from private health plans make up for losses of business to competing hospitals and physician-owned ambulatory facilities. However, as more care moves to physician-owned ambulatory sites of service through gene therapy, robotic surgery, and other 'disruptive technologies,' the role of the hospital in the health care system could change markedly."

The Medicare Payment Advisory Commission updated its March 2005 report at the end of August, noting that the number of physician-owned specialty hospitals had doubled between 2002 and 2004.<sup>3</sup>

Among its new findings is that orthopedic/surgical hospitals' inpatient costs per discharge are roughly 20 percent higher than those at competing community hospitals, and both heart and orthopedic/surgical hospitals have 20 percent to 25 percent shorter lengths of stay than community hospitals. The potential savings from the shorter length of stay, however, were not enough to offset the higher costs per discharge for orthopedic/surgical hospitals. In general, physician-owned heart hospitals are also associated with a 6 percent increase in the number of cardiac surgeries per 1,000 Medicare beneficiaries. Heart hospitals also have 26 percent of the cardiac surgery market in 2004 and obtained the majority of their market share by diverting patients from community hospitals.



Nevertheless, the Commission also found that:

"While the specialty hospitals took profitable surgical patients from the competitor community hospitals (slowing Medicare revenue growth at some hospitals), most competitor community hospitals appeared to compensate for this lost revenue. From our site visits in 2004, we learned that in some

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## Policy Perspective

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cases competitor community hospitals cut costs by cutting staff; in some cases they instituted “aggressive pricing strategies” to raise revenue from private payers; and in many cases they expanded profitable business lines such as imaging, rehabilitation, pain management, cardiology, and neurosurgery. These responses to the specialty hospital challenge coupled with population growth in many of the markets where specialty hospitals operate combined to allow competitor community hospitals to maintain profit margins that are in line with national averages.

“As physician-owned entities capture more profitable service lines, the effect on community hospitals may increase. However, we found that community hospitals’ profit margins appeared stable through 2004, even in markets where physician-owned hospitals captured more than 10 percent of all admissions.”<sup>4</sup>

## Reporting and Regulating Medical Practice

The vast amounts of data collected and published by the Pennsylvania Health Care Cost Containment Council (PHC4) provide evidence of medical practice trends with implications for state regulators, while regulation, and the absence of it, strongly influences those same trends. The public reporting of PHC4 and of the New Jersey Department of Health is described in another article in this newsletter (see page 5).

As previously reported here, the number of open-heart surgeries has been declining nationally, a trend also noted in the Philadelphia region. In the first nine months of last year, open-heart surgeries in South Jersey and Southeastern Pennsylvania declined by 8.6 percent, and bypasses by 15 percent. Many bypasses are now done without stopping the heart and using a heart-lung machine to add oxygen to the blood and circulate it through the patient's body. So-called “off-pump” bypasses are performed while the patient's heart continues to beat, potentially reducing the memory loss that can occur when a heart-lung machine is used, and bypasses have continued to become safer. According to PHC4, the mortality rate in Pennsylvania in 1991 was 4.9 percent (while it was 4.0 percent in New York), but by 2004, it had declined to about 2.0 percent. New Jersey shows similar results.

But the improvements made in stenting, together with the growing patient preference for less invasive angio-

plasty, are what are driving this trend. In South Jersey between 1997 and 2004, angioplasty volume increased by 71 percent while bypass surgeries declined by 52 percent. The declining utilization of open-heart surgery is resulting in lower volumes at the hospitals performing it. New Jersey both regionalizes open-heart surgery through its CON program and regulates it through licensure. Across the Delaware River from Southeastern Pennsylvania, only three hospitals in South Jersey are licensed for bypass surgery (and angioplasty), and in order to maintain their programs, they must perform at least 350 open-heart surgeries per year or meet certain quality standards.

Pennsylvania does neither CON nor licensure regulation. Ten years ago, its CON program lapsed, and the inevitable result was that the cardiac services that had been concentrated in Philadelphia proliferated in the area's suburban hospitals. In 1996, suburban Chester County was served by hospitals in Philadelphia, but now four of the county's five hospitals have their own cardiac surgery. Meanwhile, Philadelphia's inner city hospital programs have experienced steep declines in volume. Hahnemann University Hospital's open-heart cases dropped by 76 percent, from 1,463 in 1997 to 357 in 2004. At Temple University Hospital, open-heart surgeries fell by 64 percent, from 571 in 1997 to 203, in 2004. And today, there are 21 hospitals in Southeastern Pennsylvania doing open-heart surgery, only six of which would have met New Jersey's 350 surgeries standard in 2004.

St. Mary Hospital, a 327-bed community hospital in suburban Bucks County, on Philadelphia's northeastern border, is a good case in point. In 1996, St. Mary offered neither angioplasty nor open-heart surgery. In 2004, according to PHC4, it performed 1,272 angioplasty procedures, and it had the fifth-busiest open-heart surgery program in Southeastern Pennsylvania. In that year, it earned a surplus of \$18.2 million on \$226 million in revenues.

Another effect of improved heart care for regulators to monitor is that it has reduced the necessity for heart transplantation. The national rate has been declining slowly since 1998. This is already an issue in Philadelphia, which has five hospitals doing heart transplants. In 1997, its then three hospitals performed 172 operations, but the five hospitals did only 93 in 2005. For the base population, two would eas-

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## Policy Perspective

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ily suffice, and consequently four of these programs did no more than 13 transplants in 2005; only the Hospital of the University of Pennsylvania (HUP) had the volume for greatest proficiency – 49. Each of the three lowest volume hospitals performed fewer than 12 heart transplants. That is the minimum number of operations new transplant programs must have in a year to qualify for Medicare funding. And outcomes follow suit. At HUP, the one-year survival rate for 110 patients (2003-2004) was 90 percent, while at Hahnemann, with 20 patients, it was 75 percent. HUP's heart transplantation program is the sixth largest in the nation.<sup>5</sup>

### Universal Health Care in Pennsylvania?

Bills have been introduced in both houses of the Pennsylvania legislature to establish a single-payer, state insurance plan supported chiefly by a 10 percent levy on employer payrolls and a 3 percent individual wellness tax on all personal income. The \$40-to-\$45 billion bipartisan package would extend full health, dental and prescription drug coverage to every citizen while eliminating co-payments, caps and deductibles. It would also offer tax rebates to volunteer emergency responders and defuse the medical malpractice crisis with a no-fault program. The bills spring from a plan unveiled last year by Pennsylvania HealthCare Solutions Coalition, a grass roots organization pushing for universal coverage. A feature of the legislation is that a state agency would set payment rates, and certificate of need would be reestablished for new health care facilities. However, it is highly doubtful that the legislation will survive the lobbying of the state's insurance industry.

### California Stands Up for UHI!

Senate Bill 840, authored by State Senator Sheila Kuehl, has passed both houses of the California State Legislature. Sen. Kuehl called the passage of the bill historic because it was the first time both houses of the Legislature have passed a universal health care bill. The bill now goes to Gov. Schwarzenegger's desk. The state has between 6 and 7 million uninsured, and Governor Schwarzenegger has no alternative plan to address that, but he is opposed to single-payer plans in principle.

Several times recently this column has discussed this truly progressive legislation which is projected to save

the citizens of California almost \$8 billion in its very first year by replacing all private health insurers, but preserving the status of health care providers, hospitals, and pharmacies as private, competitive businesses, and emphasizing preventative and primary care.<sup>6</sup> The result would be a state "Medicare-for-all," where the elimination of private insurance and the state's negotiating/purchasing power over pharmaceuticals and medical equipment can realize the savings to make the plan financially feasible.

An analysis by the Lewin Group, an independent health care consulting firm, found that more than enough is already being spent on health care in California to cover everyone under this legislation. That means that the total of federal, state, business, and personal funds now being spent there can be restructured into a new integrated system that covers everyone. Business would no longer need to allocate funds for health benefits, and consumers would no longer bear the costs for insurance premiums, health care payments, and co-payments. Instead, there would be new public funding through mechanisms such as an 8 percent payroll tax and a 3 percent individual income tax. Financing of the new system would require separate new legislation.

Funding was not included in the bill because it would then have required approval from two-thirds of the Legislature, something that was not possible because of opposition from Republican legislators. And the governor will likely veto this bill, but that action will guarantee a major airing of the issue in this Fall's governor's race. Consequently, universal health insurance in California still has a long political road ahead of it.

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<sup>1</sup> Robert A. Berenson, Thomas Bodenheimer, and Hoangmai H. Pham, "Specialty-Service Lines: Salvos In The New Medical Arms Race," *Health Affairs* 25 (2006): w337-w343; <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w344v1>

<sup>2</sup>A. Gandjour, A. Bannenberg, and K.W. Lauterbach, "Threshold Volumes Associated with Higher Survival in Health Care: A Systematic Review," *Medical Care* 41, no. 10 (2003): 1129-1141; and E.A. Halm, C. Lee, and M.R. Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature," *Annals of Internal Medicine* 137, no. 6 (2002): 511-520.

<sup>3</sup>*Report to the Congress: Physician-Owned Specialty Hospitals Revisited*. MEDPAC, August 2006. [http://www.medpac.gov/publications/congressional\\_reports/Aug06\\_specialtyhospital\\_mandated\\_report.pdf](http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf).

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<sup>4</sup>Ibid., p. 9.

<sup>5</sup>The source for outcomes by hospital is the Scientific Registry of Transplant Recipients. <http://www.ustransplant.org/>. The source for all other heart transplantation statistics is the United Network for Organ Sharing. <http://www.unos.org/>.

<sup>6</sup>Steffie Woolhandler and David Himmelstein argue that a **national** single-payer system could save \$300 billion annually – more than enough to cover all of our 46.6 million uninsured. See, for example, S. Woolhandler, T. Campbell, and D.U. Himmelstein, “Costs of Health Care Administration in the United States and Canada,” *NEJM* 2003; 349:768-775. <http://content.nejm.org/cgi/content/abstract/349/8/768>. They and other physicians in the Physicians for a National Health Program have long argued for a U.S. system like that now being advanced in California. See S. Woolhandler, D.U. Himmelstein, M. Angell and Q.D. Young, “Proposal of the Physicians' Working Group for Single-Payer National Health Insurance,” *JAMA* 2003; 290:798-805. <http://jama.ama-assn.org/cgi/content/full/290/6/798>. ♦

## A Brief History of Report Cards

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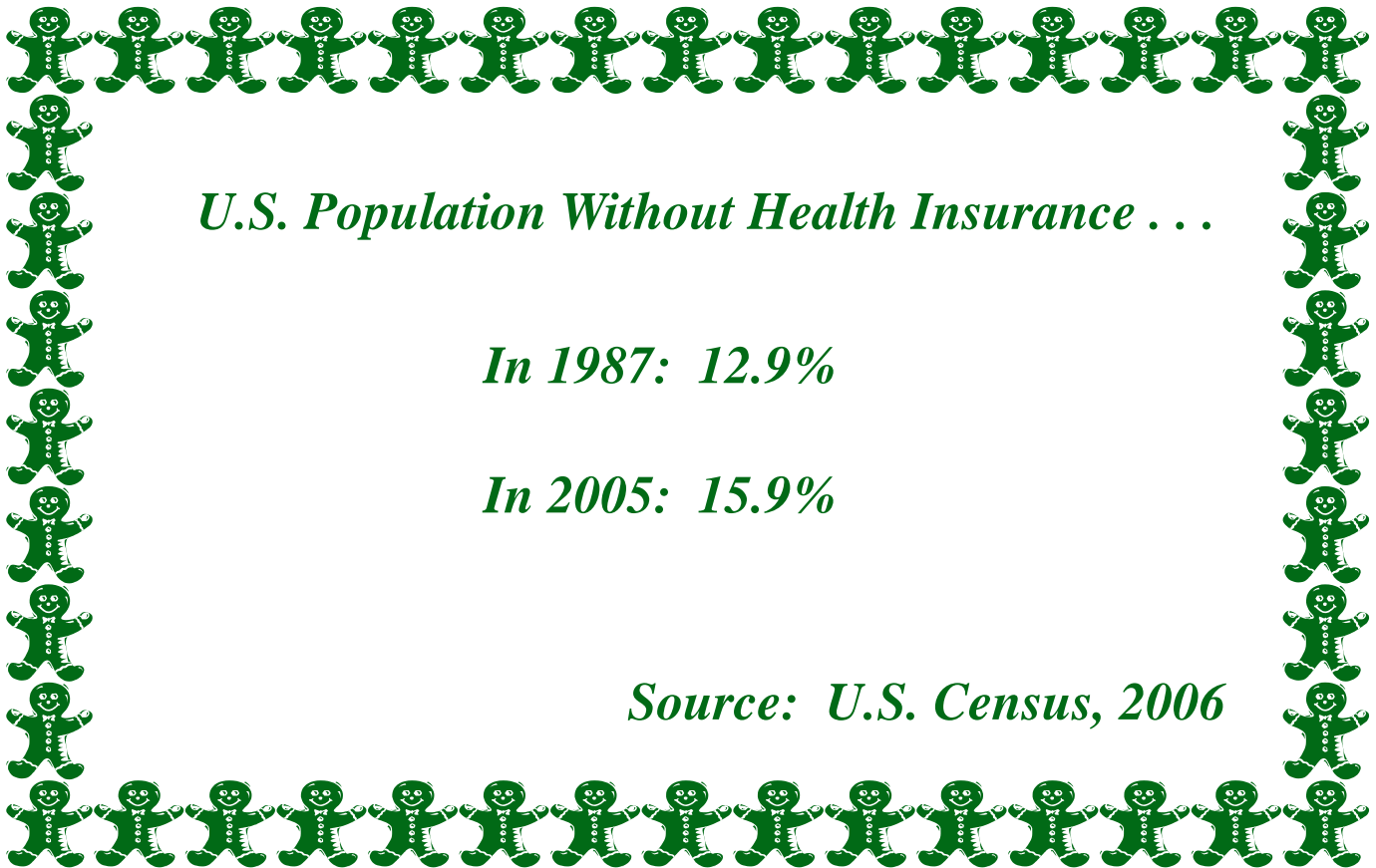
care delivery, and reporting those achievements as a function of state oversight that obviates need for “consumer-directed” shopping.

<sup>1</sup>The predictive accuracy of the New York State coronary artery bypass surgery report-card system,” Ashish K. Jha and Arnold M. Epstein, *Health Affairs*, 25, no. 3 (2006): 844-855. <http://content.healthaffairs.org/cgi/content/abstract/25/3/844>.

<sup>2</sup>This effect is better observed in longitudinal studies of the same hospital over time than in cross-sectional studies of many different hospitals at one time. See D.E. Farley and R.J. Ozminkowski, “Volume-outcome relationships and inhospital mortality: the effect of changes in volume over time,” *Med Care* 1992; 30:77-94.

<sup>3</sup>J.A. Sollano et al., “Volume-outcome relationships in cardiovascular operations: New York State, 1990-1995,” *J Thorac Cardiovasc Surg* 1999; 117:419-428.

<sup>4</sup>W.A. Ghali et al., “Statewide quality improvement initiatives and mortality after cardiac surgery,” *JAMA* 1997; 277:379-382. ♦



## 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 2006 will begin serving their new terms on January 1, 2007. All AHPA members in good standing are eligible to serve on the Board..

There are usually 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 highest quality and most reasonable cost. The Board also believes that a public decision-making process that is sensitive to community values, to the concerns of consumers, providers, and payers, and to the needs of underserved 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](http://www.AHPAnet.org).

If you wish to nominate another member or are interested in being nominated (self-nominations are permitted), please complete and return the nomination form on the next page by October 15, 2006 to:

AHPA Nominations Committee  
American Health Planning Association  
7245 Arlington Blvd., Suite 300  
Falls Church, VA 22042  
[APHAnet@aol.com](mailto:APHAnet@aol.com).

If you have questions or require additional information, please call (703) 573-3103 or send an e-mail.

Your involvement and support is needed and invited.

### *Asking the Right Questions*

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In this, they saw themselves as trustees for the interests of the communities that truly owned the resources they had tapped and expanded. They still knew how to ask, "*If I am only for myself, then what am I?*"

Education is key to this because these are the ultimate questions for all of us: What is the healthy life? So it all leads back to Socrates/Plato and Aristotle. Are you surprised? And from them we get some fundamental clarifications for our thinking. One is that nothing requires us to adopt a moral perspective for our vision. It has to be our own bent as a person to see these ques-

tions within a moral context and to use a moral compass in deciding them. How else to see compassion and reverence for life as the greatest human qualities, and good government's fostering of egalitarian principles of human rights and social justice through public health as the right health care system? For it is universal health *car-ing* that we most lack in our country now, and the effort to restore it should have what William James called "the moral equivalent of war."

Winston Churchill's prosecution of World War II solidified his small nation through such an approach, and at the time he stated that "Americans always try to do the right thing -- after they've tried everything else." Haven't we done that by now? *And, if not now, when?* ♦

# AHPA Board of Directors Nomination Form

(Nominations should be submitted on one page and returned by October 15, 2006)

Name, Title, Address, Phone, Fax, E-mail:

Education:

Professional Experience:

Professional & Community Associations:

Additional Comments:

AHPA Member Submitting Nomination:	
_____ Nominator's Name (Print)	_____ Nominator's Signature
_____ Organization	_____ Date
_____ Address	_____ Phone
_____ City/State/Zip	_____ E-mail

Acceptance of Nomination:
Check one:
<input type="checkbox"/> _____ Nominee's Signature:
<input type="checkbox"/> See Attached Letter

Return to: Chair, APHA Nominating Committee, 7245 Arlington Blvd., #300, Falls Church, VA 22042 — AHPAnet@aol.com