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Health Planning TODAY

the newsletter of the

American Health Planning Association

Following the Money

AHPA Staff Writer

According to Jesse "Big Daddy" Unruh, the late California State Assembly Speaker, "money is the mother's milk of politics." Shortly thereafter Watergate investigators were advised to "Just follow the money." With this advice in mind, we take a quick look at recent federal campaign contributions by health care interests.

Over the last ten national election cycles (1990 through September 2008) the health care sector has contributed nearly $425 million to candidates (and parties) for federal offices. Over the last two decades, the health care industry ranked fifth highest, among 80 economic sectors, in the amount contributed per election cycle. During this period, 64% of the total contributed came from individuals and 36% from political action committees (PACs).

In eight of the ten elections between 1990 and 2008, Republicans received substantially larger amounts than Democrats. On average, Republicans received more than 57% of the monies contributed; Democrats nearly 43%. It is notable that the party contribution differential has been substantially greater than the vote differential. So, to some degree, the contributions are pushing an outcome as well as responding to entrenched power.

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Following the Money

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Federal Election Contributions
Health Care Industry, 1990 - 2008

Year	Industry (Sector) Rank	Total Contributions	% Dem	% Rep
2008	5	$63,591,288	53%	47%
2006	6	$54,424,011	37%	62%
2004	6	$74,153,217	38%	62%
2002	6	$42,413,199	38%	62%
2000	5	$47,701,522	42%	57%
1998	5	$31,459,950	41%	59%
1996	5	$37,704,729	36%	64%
1994	2	$30,435,669	45%	54%
1992	5	$27,833,242	51%	49%
1990	2	$15,251,694	49%	50%
Total	**5**	**$424,968,521**	**42%**	**57%**

Source: Center for Responsive Politics. See: www.opensecrets.org

The amount contributed in each election cycle increased from the previous comparable cycle. As might be expected, the amount contributed was much higher in presidential election years that in off-year congressional elections.

The 2008 election promises to differ significantly from the previous nine cycles. If the flow of money is a good indicator, democrats are on a roll. For the first time since 1992, when Democrats received a bare majority (51%) of health industry contributions, Democratic candidates are likely to get a clear majority (53% so far) of the total contributed.

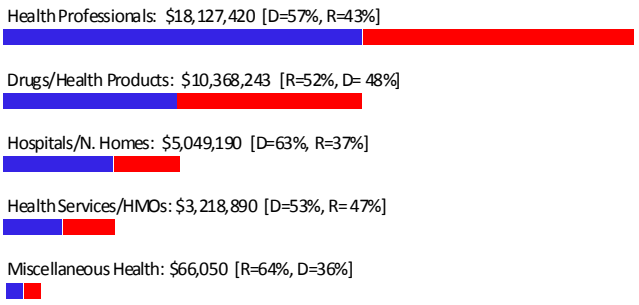
This reversal is dramatic. During the last three election cycles (2002-2006) Republicans received about 62% of the sector's contributions. Contributions from individuals represent a notably higher percentage of total contributions. As of late September, more than 71% of sector contributions are from individuals.

2008 PAC Contributions

Reported political action committee (PAC) contributions to date (9/29/2008) have been more heavily democratic (55%) than have individual contributions (51%). This probably is a function of the extended, tightly contested Democratic presidential primaries. The number of health sector PACs and PAC contributions have increased steadily over the last two decades. Between 1998 and 2008, for example, the number of health sector PACs increased 52%, from 215 to 327. PAC contributions increased 100%, from $18,364,480 to $36,829,793.

Federal Election Campaign Contributions
Health Care Sector PACs, 2008

Total Contributions	$36,829,793
Contributions to Democrats (55%)	$20,294,143
Contributions to Republicans (45%)	$16,536,475
Number of PACs Contributing	327



Source: Center for Responsive Politics. See: www.opensecrets.org

Within the sector, hospitals, nursing homes and health care professionals heavily favor democratic candidates in 2008. Historically, the drug and health products industries have strongly favored Republican candidates. They continue to favor Republicans, but by a smaller margin in 2008 than at any time in the last two decades.

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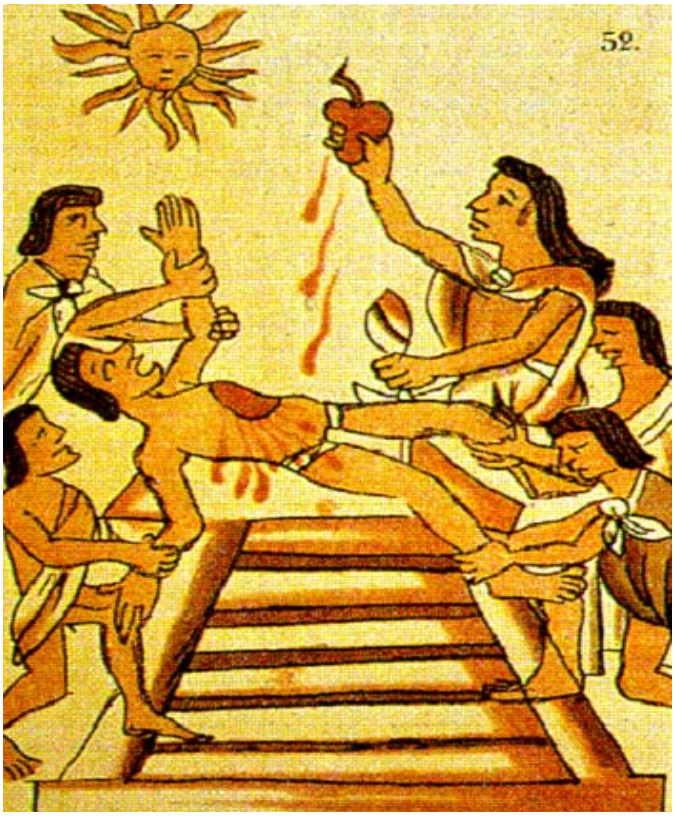
Primary PCI in Maryland
An Update on the CON Waiver Program

By Paul Parker

In 2006, this newsletter included a report on the initiation of a new program in Maryland that allows qualifying hospitals to obtain a "waiver" from the requirement, embodied in state heath planning policies, to have an on-site cardiac surgery program in order to provide percutaneous coronary intervention (PCI).[1] This program grew out of the research of the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) and the work of a Maryland cardiac services advisory committee. Maryland established a process by which hospitals without on-site cardiac surgery programs could obtain authorization to provide "primary" PCI, i.e., PCI performed on an emergency basis for specific types of patients with certain types of acute myocardial infarction. In the Spring of 2006, the first group of hospital applications for this waiver, all for Baltimore-area facilities, were approved by the Maryland Health Care Commission, which, among other things, is the state's CON agency.

Faith Based PCI (Circa 1167)



Since that time, one of the first group of facilities relinquished its waiver, due to low levels of use. The remaining initial group has been able to improve performance to a point where the group is now operating under full two-year waivers. (Hospitals obtaining a waiver for the first time may only obtain conditional one-year waivers, with two-year waivers possible upon renewal if the primary PCI programs perform up to standards.) An additional Metro Baltimore hospital has obtained a one-year conditional waiver, and another hospital in the region has been approved to develop a primary PCI program. New programs have up to a year to put all the required program elements in place and initiate primary PCI services under a one-year conditional waiver.

Three hospitals in the state's Metropolitan Washington D.C. region have qualified for two-year waivers. One hospital in the Metro D.C. area also relinquished its waiver due to low levels of use. New programs at two hospitals in Western Maryland are now operating under one-year conditional waivers.

Obtaining a waiver requires demonstrating compliance with a number of requirements, touching on the areas of institutional resources, physician resources, minimum volumes of appropriate patients, and minimum volumes of primary PCI procedures.

Among these requirements are:

- The availability of primary PCI as routine treatment of choice for all appropriate patients 24 hours per day, seven days per week;
- Provision of primary PCI as soon as possible and not to exceed 120 minutes "door to balloon," for 80% of patients;
- Formal, written agreement with an advanced cardiac life support EMS provider that guarantees arrival of the air or ground ambulance within 30 minutes of the primary PCI hospital request;

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Primary PCI in Maryland

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- Formal, written agreements with tertiary-level hospitals that guarantee acceptance of primary PCI patients needing transfer to such facilities for cardiac surgical services;
- A minimum of 75 PCI cases per year for all physicians performing primary PCI (consistent with ACC/AHA criteria for competency); and
- Performance by the hospital of a minimum of 36 and, optimally, 49 primary PCI procedures annually. The lower volume applies to areas of the state where access to high volume programs is not readily available.

Additionally, all hospitals obtaining a waiver must participate in supplying information to a PCI database that is used to monitor process and outcome measures.

Since initiating the waiver program, the waiver hospitals have shown strong progress in improving a key performance factor, the critical "door-to-balloon" time. Patients with the most dangerous category of heart attack, ST-segment elevation myocardial Infarction (STEMI), need fast revascularization of the blocked coronary artery through PCI to reduce damage to heart muscle and improve the patient's chances for survival and long-term potential for recovery. Median door-to-balloon times for primary PCI in hospitals without on-site cardiac surgery have declined from 119 minutes in the first quarter of 2006 to 83 minutes in the last quarter of 2007. The proportion of total primary PCI patients in hospitals without on-site cardiac surgery who experienced a door-to-balloon time of less than 120 minutes increased from approximately 60% to nearly 89% over the same period.

As noted in the 2006 article, these developments in the regulation of primary or emergency angioplasty under Maryland's State Health Planning program provide some insight on how one regulated service sector, interventional cardiology, may be evolving in a manner that differs from the traditional CON regulatory model. The article noted that

"Like the traditional medical facilities licensure model, this waiver program requires an applicant to demonstrate ongoing compliance with certain minimum requirements and to obtain renewal of their waiver status on the basis of continued compliance. Unlike traditional medical facilities licensure, and more like CON regulation, there are minimum service volume requirements. And unlike either traditional facilities licensure or CON, there are quantified performance targets that must be met, in addition to more simple structural and process measures."

Based on the limited experience gained in the first two years of this program, the model holds promise as a different regulatory approach, combining features of both traditional supply-side regulation, such as CON, and medical facilities licensure.

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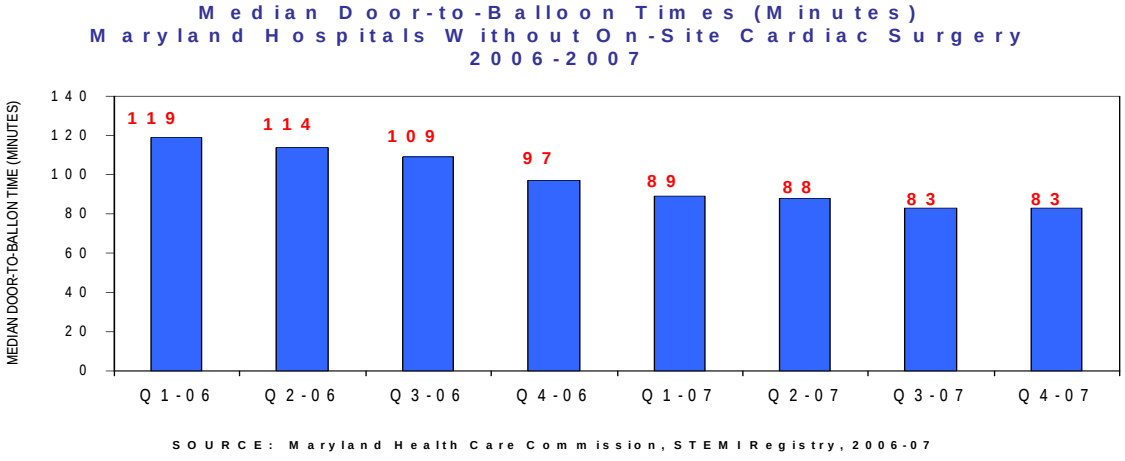

What Health Care System?

By John Steen

The title of this article is meant to convey at least two aspects of our current discussions on health care: we don't have a national system, and we have the opportunity to design one, for which there are several models.

Those nations that do have national health care systems conform to one of three major structural models. From greater to lesser diversity and complexity, and from lesser to greater government involvement, the models are:

1. Universal health insurance is provided by "social insurance funds" or "sickness funds" that are highly regulated and not-for-profit. They also permit a limited role for private insurance in filling gaps in coverage. Examples: Germany, France, Japan, the Netherlands, and Switzerland.
2. There is a government-run insurance plan that covers everyone, and most physicians are in private practice. It functions like Medicare, and Canada is a well-known example. Other examples are the Scandinavian countries, Australia, and Taiwan.
3. The health care delivery system is government-owned and care is delivered as a government service by salaried physicians. Our best known example is the Veterans Administration Health System. The U.K., Spain, and Cuba have such systems.

It isn't the economic and social efficiency of these models that Americans notice. We most notice the political context each brings with it. The first two models represent socialized insurance; only the third is socialized medicine. The only role for profit making in any of these is the "gap coverage" in the first. The ill-fated 1993-94 Clinton Health Reform Plan was modeled after the first of these models too. The Veterans Administration Health System is the only fully integrated, complete health system we have in America, and that permits it to better employ IT and to excel at quality assurance better than all the others.

In America, health care is seen as a commodity to be purchased, but all of these national models recognize health care as a social good to be shared, so they are universal. Donald Light has studied these health care systems and identified ten benchmarks that foster a "justice-based" health care system. Among these benchmarks are: universal participation regardless of health condition, risks and ability to pay; minimizing non-financial barriers; comprehensive and uniform services; equitable financing through community-rated contributions and ability to pay; value through clinical and financial efficiency; public accountability; and choice of providers.[1] About our "system," he has this to say:

> "… [O]ne could say that most societies have approximately the health care system that reflects what their business, professional, and political elite have wanted. This implies that we are unlikely to attain a health care system too much more ideal than the society in which we live. In the United States, we developed a health care system that reflected the priorities of the elite political and business: minimal governmental involvement or regulation, maximum free choice for patients and providers, the unfettered pursuit of high-tech subspecialty medicine, private voluntary insurance, and a capitalist dream of protected high-growth markets. These features led to a health care system with a high percentage of unnecessary tests, prescriptions, and procedures; by far the highest administrative costs in the world; the highest prices and costs in the world; a neglect of public health, prevention, and primary care; and one of the greatest misfits between health care needs and health care services."[2]

The society in which we live was created out of the most progressive thinking about human rights extant over two centuries ago, directed toward forming "a more perfect union." We haven't done that for health care, and we cannot do it without "the consent of the governed." Do Americans even realize that the rest of the world desires our leadership and expects us to

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What Health Care System?

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develop a sound health care system for our own benefit as well as theirs?

Making Universal Health Care Universal

The Commission on Social Determinants of Health (CSDH), a commission of the World Health Organization (WHO) composed of an eminent group of 19 independent policy makers, academics, former heads of state, and former ministers of health, delivered a long-awaited report[3] to the WHO on August 28. Launched in March 2005, the CSDH was mandated to investigate and report on evidence to guide action on social determinants of health to reduce health inequities. Among the worst causes of poor health and inequalities between and within countries identified by the CSDH are unemployment, unsafe workplaces, urban slums, globalization, and lack of access to health systems. In its report, the CSDH recommends that all nations provide universal health care based on assured access to primary health care, and that this be funded by general taxation and/or mandatory universal insurance. It expresses concern over a growing commercialization of services that threatens the sustainability of health care systems. "… [The] toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible," according to the CSDH.

Health equity through action on the social determinants of health should be a principal measure of the performance of governments, according to the report. "We rely too much on medical interventions as a way of increasing life expectancy," explained CSDH chair Sir Michael Marmot.[4] "A more effective way of increasing life expectancy and improving health would be for every government policy and programme to be assessed for its impact on health and health equity; to make health and health equity a marker for government performance."

Health equity is a key concept for the CSDH, which states:

> "… [H]ealth equity depends vitally on the empowerment of individuals to challenge and change the unfair and steeply graded distribution of social resources to which everyone has equal claims and rights. Inequity in power interacts across four main dimensions – political, economic, social, and cultural – together constituting a continuum along which groups are, to varying degrees, excluded or included."[5]

The report finds that the good health of the Nordic countries is rooted in commitment to universalist policies such as equality of rights to benefits and services, full employment, gender equity and low levels of social exclusion. Professor Marmot said:

> "Central to the Commission's recommendations is creating the conditions for people to be empowered, to have freedom to lead flourishing lives. Nowhere is lack of empowerment more obvious than in the plight of women in many parts of the world. Health suffers as a result. Following our recommendations would dramatically improve the health and life chances of billions of people."

Guided by its ideal of social justice, the CSDH report issues four recommendations addressing political empowerment, including:

> "National- and local-level government ensure the fair representation of all groups and communities in decision making that affects health, and in subsequent programme and service delivery and evaluation."[6]

The report sums up the relation between health determinants and health inequity as follows:

> "The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon."

The CSDH reports that in the U.S., 886,202 deaths would have been averted between 1991 and 2000 if mortality rates between whites and African Americans were equalized.[7]

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Radiation Therapy Developments, Trends

Overall cancer incidence, prevalence, and mortality have decreased over the last decade and a half.[1] Even with an increasing percentage of newly diagnosed cancer patients receiving radiation therapy, decreased incidence has resulted in the total number of radiation therapy patients seen nationally remaining relatively stable, in a range between 950,000 and 1.0 million per year. The total number of treatment visits (number of separate radiation therapy treatment sessions) continues to increase. Service providers reported approximately 24.5 million treatment visits in 2007, about 5% higher that the 2006 total.[2] There are now about 2,100 treatment sites (hospital and non-hospital) nationwide. Treatment sessions per patient (initial and second courses of treatment combined) now average about 25.5.

Stable demand notwithstanding, spending on (investment in) radiation therapy is proceeding apace. Notable trends include the

- Continuing shift from hospital to freestanding therapy centers,
- Consolidation of the market, particularly among the freestanding services,
- Development of multimodality "oncology centers,"
- Incorporation of digital imaging in treatment planning and in guiding tumor irradiation, and
- Adoption and incorporation of stereotactic radiosurgery (SRS) capability.

Technological change has been rapid. In 2004, for example, only about 15% of services reported had image-guided radiation therapy (IGRT) capability. More than half of service sites now offer image-guided therapy. Another advanced treatment technique often used in tandem with IGRT is intensity-modulated radiation therapy (IMRT), which is now available at nearly 90% of radiation therapy sites.

Digital imaging makes it possible to direct and modulate treatment in accordance with real time images taken before and during tumor irradiation. CT and ultrasound are the primary imaging modalities used in image-guided procedures.

There has been a wholesale shift to the use of CT scanners in treatment planning. More than 90% of the treatment simulators now being installed are CT scanners, typically high-speed scanners (see table below). MRI and PET are used to a lesser extent. Treatment planning that incorporates PET is being used in about 11% of centers.

Technologic advances in the electronic management of planning and treatment data have also proceeded quickly. Picture archiving and communications system (PACS) networks are now used in more than 90% of therapy programs, compared with about 60% five years ago. Most PACS networks accommodate a variety of medical imaging modalities, including CT, MRI, PET, endoscopy, ultrasound, and mammography.

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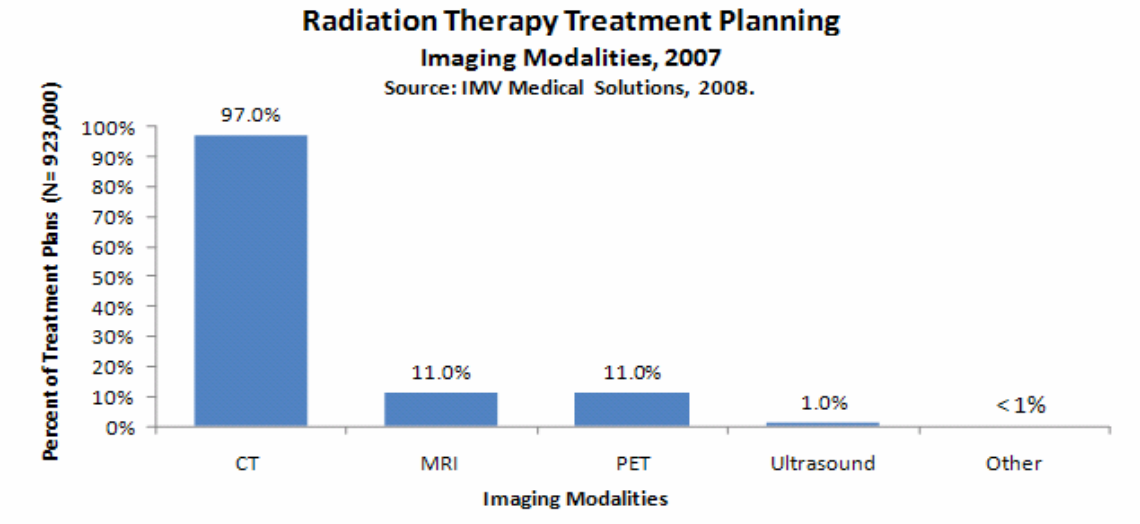

Radiation Therapy Developments, Trends

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More than half of radiation therapy treatments are for three types of cancer: prostate (21%), breast (20%), and lung (13%). The tandem use of real time IGRT and IMRT is especially useful in the treatment of prostate, lung, head and neck, breast, and tumors because it permits the application of higher radiation doses to tumors with less radiation and risk to health tissue.

The radiosurgery market appears to be shifting, moving from the fixed, single fraction doses delivered with a Gamma Knife® (Elekta) to the more flexible Cyber Knife® (Accuray) and, especially to the more flexible and less costly Trilogy (Varian) system. Both the Trilogy and the Cyber Knife® can be used to provide "radiosurgery" throughout the body in a small number (usually 2 to 5) of fractions.

[1] *Cancer 2007*; 110:2119-52, American Cancer Society, 2007.

[2] IMV, Medical Information Division, Ltd., 2008

Primary PCI in Maryland

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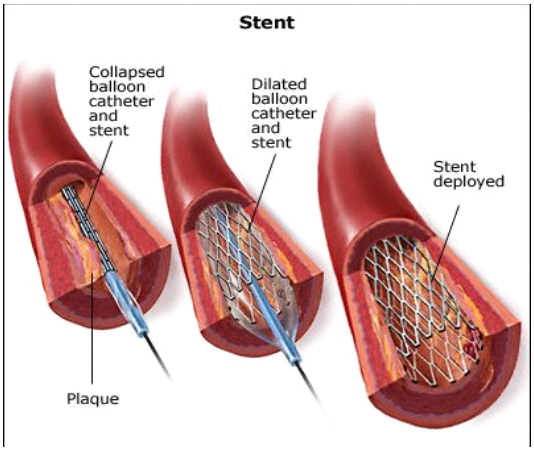
Maryland is currently completing the first phase of reviewing applications from hospitals to participate in a new research program which will evaluate the safety and effectiveness of delivering non-primary PCI in hospitals without on-site cardiac surgery.

[1] "Primary PCI in Maryland Hospitals Without Onsite Cardiac Surgery, 2nd Quarter, 2006, Vol. XXVIII, No. 2, p.5.



Following the Money

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Health Care Professionals

The contribution patterns of health care professionals are distinct. Over the last two decades, hospitals, nursing homes, chiropractors, and medical groups have, on average, contributed more or less equally to Democrats and Republicans. As with most interests, they have contributed disproportionately to the party in power and tailored their contributions accordingly.

The two exceptions are dentists and nurses. Dentists have consistently supported Republicans. During the last two decades, dentists have favored republican candidates by nearly two to one. Dentists contributed more to Democrats than Republicans in only one of the last 10 election cycles, the presidential election of 1992. Dentists continue to give disproportionately (58%) to Republicans in 2008.

Nurses have consistently favored Democrats, even when Republicans controlled all branches of the federal government. Over the last two decades they have contributed nearly twice as much to Democrats as Republicans., and have heavily favored democrats in each of the last 10 election cycles. In 2008, about 62% of the total contributed by nurses has gone to Democratic candidates.

Federal election records do not indicate where the big health planning money is going. But you heavy hitters should give and give again. Remember the sage advice of the late great Harlan "Colonel" Sanders: "There's no reason to be the richest man in the cemetery. You can't do any business from there."

Policy Perspective

By John Steen

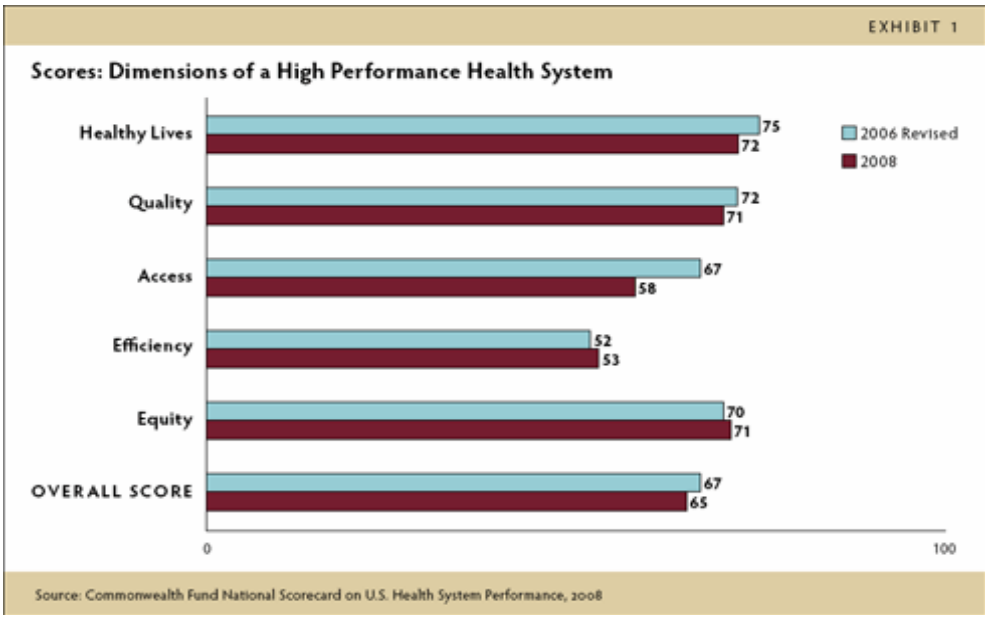
More Scorecards

In July, the Commonwealth Fund issued its second biannual report card, *Why Not the Best? Results From The National Scorecard on U.S. Health System Performance, 2008*,[1] which assesses the United States on 37 health care measures and provides comparisons with other nations. U.S. average performance is compared with benchmarks drawn from the top 10 percent of U.S. states, regions, health plans, hospitals, or other providers or top-performing countries, with a maximum possible score of 100.

Using World Health Organization (WHO) data, it finds that the U.S. now receives an overall score of 65 out of 100, a decrease of two points from 2006. In addition:

- For access to care, the U.S. receives a score of 58 out of 100, a decrease of nine points from 2006.
- For health care efficiency, the U.S. received a score of 53 out of 100, in part because of widespread delivery of inappropriate and wasteful care throughout the U.S., including potentially avoidable hospital admissions, minimal use of information technology, and high insurance administrative costs.
- For potential overuse or waste, the score was just 41.
- Up to 101,000 fewer people would die prematurely each year from causes amenable to health care if the U.S. achieved the lower mortality rates of leading countries.
- Reducing health insurance administrative costs to the average level of countries with mixed private/public insurance systems (Germany, the Netherlands, and Switzerland) would free up $51 billion per year, or more than half the cost of providing comprehensive coverage to all the uninsured in the U.S.
- Reaching the lowest rate benchmarks (2% to 3% of national health expenditures spent on administrative costs) set by the lowest countries – Finland, Japan, and Australia – could save an estimated $102 billion annually.
- More pointedly, the U.S. scored last among 19 nations in preventable mortality, just below Ireland and Portugal. France ranked first, followed by Japan and Australia.

At the same time, *The Measure of America: American Human Development Report 2008-2009*[2] was issued by a foundation that includes Oxfam America, the Rockefeller Foundation, the Conrad Hilton Foundation, and the Social Science Research Council. It looked at U.S. government data on health, education, and income, ranking us 12th for human development based on the United Nations' Human Development Index (HDI),[3] 42nd in life expectancy, and 34th in terms of infants surviving to age one. It reveals inequalities between the richest and poorest Americans, noting that the HDI shows that people in last-ranked Mississippi are, in terms of development, living 30 years behind those in first-ranked Connecticut. The richest 20% of Americans earn on average *$168,170*



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a year, almost 15 times the average of the lowest 20%, who earn only $11,352. Asian males in the U.S. were found to have the highest HDI score and were expected to live 14 years longer than African-American males, who had the lowest HDI rating. The average American had a longer life expectancy 30 years ago than African-Americans have today. The report breaks down its data to the Congressional District level. What it ultimately reveals is how poorly our public and private policies meet the needs of all Americans, the souring of the American Dream. The U.S. ranks first among the world's 25 richest countries in the percentage of children living in poverty. A poor child born in Germany, France, Canada, or one of the Nordic countries has a better chance to join the middle class in adulthood than an American child born into similar circumstances.

The United Nations has conducted similar studies on over 140 developing countries, but this is the first time a group has issued one on the United States. The HDI ranks Iceland, Norway, Australia, and Canada highest in that order.

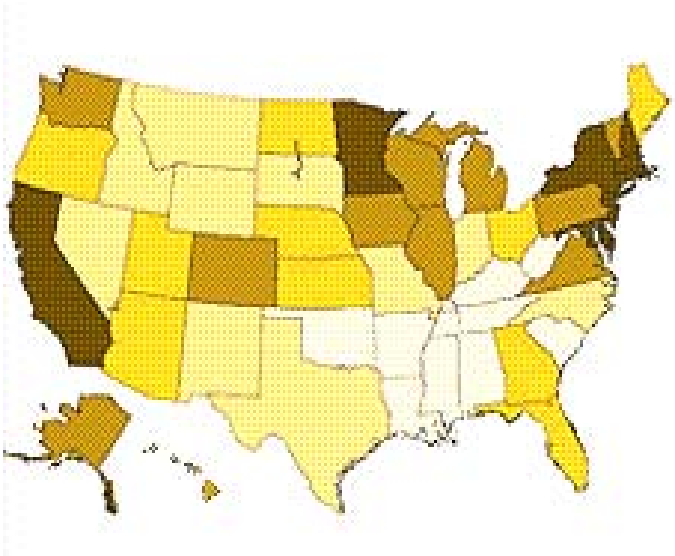
The report includes an eight-point human development agenda that touches on major areas in which action is needed to raise the American HD Index score in the coming years. These are:

1. Promote prevention and public health.
2. Make health care affordable for all Americans.
3. Modernize K-12 education.
4. Invest in at-risk children, the earlier the better.
5. Strengthen and support families to better balance work and family responsibilities.
6. Boost incomes and aid asset-building.
7. Launch a Marshall Plan for the Gulf (the region with by far the lowest HDI).
8. Take responsibility for the most vulnerable.

Validation of Public Reporting

Regionalization of specialized hospital services has been shown in many good quality research studies to result in superior outcomes (primarily lower mortality) at lower unit cost. A related question that has been more difficult to answer definitively is to what extent, if at all, public reporting initiatives ("report cards") further improve those outcomes. A large new observational study[4] may finally do just that.

HDI: States (higher ranking are darker)



The State of Pennsylvania offers the best example of public reporting of hospital outcomes. Along with New York and California, it has been doing that for two decades, and it has reported on a broader set of services than have other states.[5] The study examined six high-frequency, high-mortality medical conditions (acute myocardial infarction, congestive heart failure, hemorrhagic stroke, ischemic stroke, pneumonia, and sepsis) and used propensity score methods to compare Pennsylvania patients with those in 60 hospitals in 20 other states, with the patients matched for medical condition. The 20 other states represented varying public reporting environments. By selecting acute conditions rather than elective procedures, the researchers avoided the confounding effects of changes in elective referral patterns in surgical cases.

Patients treated at hospitals subjected to intensive public reporting were found to have had significantly lower odds of in-hospital mortality when compared with similar patients treated at hospitals in environments with no public reporting or only limited reporting. Researchers looked at two recent periods, 1997-1999 and 2000-2003, finding greater improvement among Pennsylvania patients in the later period, during which reporting was more intensive, suggesting that the improvement resulted from public reporting. And they

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found no significant difference in mortality between patients treated in Pennsylvania and those in three other states where outcomes were also being reported for the same clinical conditions, supporting the thesis that it is public reporting rather than Pennsylvania that gets the credit.

Measuring State Resources and Access

Now that the states are experimenting with various ways of improving access to health services, primarily by extending health insurance coverage, interest in their relative success is growing. To satisfy that interest, the University of Minnesota's State Health Access Data Assistance Center (SHADAC) produces an interactive chartbook in which all 50 states and the District of Columbia may be compared.[6] In addition to health insurance coverage, it offers measures for health care resources (doctors as well as hospitals), including safety-net resources (public hospitals and clinics).

Lessons in Public Health Ethics

Africa is replete with lessons for public health due to its demonstrating such extreme need in so many areas. A study[7] recently conducted in Ghana offers a paradigm for public health everywhere. The study addressed the trade-offs implicit in choices between equity and efficiency in making resource allocations. Especially where resource availability falls well short of overall needs, there is the incentive to be cost effective in one's decisions. But such decisions can compromise one's perceptions of fairness.

In Ghana, 63 policymakers representing its Ministry of Health convened to assess the relative importance of criteria for prioritizing health needs that were established by a focus group of seven public health experts. Regression analysis was used to rank order a set of health interventions on the basis of these criteria and the weights associated with them. Innovative economic experiments were employed to assess the value of interventions that produce less health improvement, but target the poor, the severely ill, or otherwise disadvantaged populations. The policymakers considered fairness to be at least as important as efficiency in making their decisions. They considered targeting of vulnerable populations and cost-effectiveness as the most important criteria for priority setting of interventions, followed by severity of disease, number of beneficiaries, and diseases of the poor. This translates into a general preference for interventions in child health, reproductive health, and communicable diseases. The result of such a process is transparency and accountability in policymaking, as well as evidence for promoting a human rights agenda in reducing vulnerabilities.

The lesson here is that public health must view society as its patient and inquire as to how much social justice there is in it. That point was definitively established by Jonathan Mann with respect to HIV/AIDS: Curing a sickness *in* a society requires us to cure the sickness *of* that society. The new Global Report,[8] issued biennially by UNAIDS, includes data that show a direct correlation between the presence of discriminatory laws criminalizing marginalized populations, such as men who have sex with men (MSM)[9] and people who use drugs, and the absence of services for those populations. Where human rights are compromised,[10] public health will be ineffective in preventing as well as treating this pandemic. It flourishes where there is poor education and gender inequality. What is most needed to prevent it is comprehensive sex education that actively involves young people themselves. Instead we promote only abstinence as an approach to risk reduction, prohibit any support for or empowerment of commercial sex workers, and oppose needle and syringe exchange for injection-drug users. In this regard, the role of the U.S. makes us the problem where we ought to be the solution.[11]

Our efforts to combat the spread of HIV/AIDS at home are even more politically and socially weakened than they are abroad, with consequences that raise questions of social justice here. The CDC's HIV prevention budget has remained at roughly $700 million since 2001, an actual reduction of 19% when adjusted for inflation.[12] CDC's former director of HIV Prevention Services has estimated that CDC needs about $1.3 billion to address those needs it has already identified in this country.[13] Approximately 56,300 new HIV infections occurred in 2006. And about 42% of its fiscal 2007 funding was targeted at gay and bisexual men, but 53% of new HIV infections occurred in MSMs. Of the new infections, 73% are in men, and 53% in MSMs;

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45% are in non-Hispanic blacks, and 17% are in Hispanics – rates of infection that are, respectively, seven times and three times those among whites.

A truly bizarre instance of criminalizing victims occurred in May when Texas sentenced a man to 35 years in prison for spitting on a police officer. The sentence length reflects that that man was HIV-positive, but better reflects our scientific and moral ignorance. The CDC has confirmed that spitting cannot transmit HIV, and criminalization of a disease is not a treatment for its victims. In fact, we must see as sick a society that punishes someone for being a victim. Where such abuses are prevalent, the government itself must be public health's true patient.

And this being a national election year, we once again have the responsibility to improve our government. I see this pandemic as a litmus test for the candidates' thinking about our society and its government. Senator McCain has not put forth a formal plan or strategy to address HIV/AIDS domestically or globally, or global health more generally.[14] Senator Obama did all of this in 2007. He supports comprehensive sex education and federal funding for needle-exchange, and he would focus on eliminating disparities in the pandemic's impact, particularly in minority communities. He proposes to provide $50 billion by 2013 for U.S. global AIDS efforts through the President's Emergency Plan for AIDS Relief (PEPFAR), an increase of $35 billion in that program's funding,[15] and expand it to places like Southeast Asia, India, and Eastern Europe. He also supports increased U.S. investment in the health infrastructures of developing countries so they can better address public health challenges.[16] A social justice approach is evident in his statements:

> "Combating HIV/AIDS also demands closing the gaps in opportunity that exist in our society so that we can strengthen our public health. We must also overcome the stigma that surrounds HIV/AIDS – a stigma that is too often tied to homophobia."[17]
>
> "I'll work to dispel the stigma surrounding this disease, which is what Michelle and I tried to do by taking a public HIV test in Kenya a while back…. And we'll work to eliminate the extreme poverty that permits HIV/AIDS, tuberculosis, and malaria to flourish by doubling our foreign assistance from $25 billion per year to $50 billion per year by 2012."[18]

California Tries Again

Early on Labor Day, the California State Legislature again passed SB 840[19] and sent it to Governor Schwarzenegger for his signature. He vetoed it two years ago, saying "I must veto SB 840 because I cannot support a government-run health care system," but he has seen his own efforts to establish a statewide health insurance plan fail in the interim and dramatic erosion of the state's "safety net" for Californians. SB 840 is similar to HR 676, and its passage in California could presage serious discussion of that "Medicare for All" bill in Congress next year. In any case, SB 840 would establish a true health care system far superior to the Massachusetts Plan. The real political courage in SB 840 consists in its elimination of private insurance plans. Now we'll see if the governor can muster the political courage displayed by Massachusetts in securing passage of its Plan, however flawed. Its decision will be based on exactly the same alternatives that face the Congress: universal coverage or further denigration of the role of government.

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[1] For the report, go to: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=692682

[2] Authored by Sarah Burd-Sharps, Kristen Lewis, and Eduardo Borges Martins and published by Columbia University Press. For the report, go to: http://measureofamerica.org/.

[3] The HDI was developed in 1990 by Amartya Sen, who said: "Human development is concerned with what I take to be the basic development idea: namely, advancing the richness of human life, rather than the richness of the economy in which human beings live, which is only a part of it."

[4] Christopher S. Hollenbeak et al., "Reductions in Mortality Associated With Intensive Public Reporting of Hospital Outcomes," *American Journal of Medical Quality*, 23:4, Jul/Aug 2008, 279-286. http://ajm.sagepub.com/cgi/reprint/23/4/279.pdf.

[5] The Pennsylvania Health Care Cost Containment Council (PHC4) currently produces annual reports with quarterly updates on 50 procedure and treatment groups.

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[6] Go to: http://www.rwjf.org/newsroom/interactive.jsp?id=35

[7] Caroline Jehu-Appiah, Rob Baltussen et al., "Balancing Equity and Efficiency in Health Priorities in Ghana: The Use of Multicriteria Decision Analysis," *Value in Health*, 11:6, November/December, 2008. Published online, 15 Jul 2008: http://www3.interscience.wiley.com/journal/120776362/abstract.

[8] In connection with its release, UNAIDS Executive Director Dr. Peter Piot said that the global food crisis "is affecting also the fight against AIDS. And we have the paradoxical situation that some people have access to pretty expensive and sophisticated drugs but have no food to eat…." The report is accessible at: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp.

[9] The incidence of new HIV infections is rising fastest among MSMs, but less than 1% of the $669 million reported in global prevention spending targets MSMs, according to UNAIDS figures from 2006, the latest available data. These men receive the lowest coverage of HIV prevention services of any at-risk population. And AIDS rates among gay and bisexual men are often found to correspond to the degree of homophobia in a country. Eighty-five countries have laws criminalizing sex between men. It is punishable by death in seven of them, and by imprisonment in 76. After a quarter-century of research, prevention, and treatment, HIV/AIDS remains a tragic problem for public health and human rights.

[10] "… [H]uman rights are inalienable and thus belong to everyone, including those who come from highly stigmatized groups or are regarded as alien by a community," said Kyung-wha Kang, the United Nations' Acting High Commissioner for Human Rights in an op-ed column in the *Miami Herald*, August 6, 2008. Accessible at: http://www.miamiherald.com/opinion/other-views/story/630714.html.

[11] However, U.S. aid to 15 African nations has been quite effective in improving treatment: Some 1.7 million people are receiving antiretroviral therapy through the President's Emergency Plan for AIDS Relief (PEPFAR). Yet this represents only about one-third of those in need of treatment. See: http://www.pepfar.gov.

[12] It is even more telling that while PEPFAR devotes 22% of its funding to prevention, only 4% of federal HIV funding goes for prevention at home.

[13] In a federal employee survey released in 2007, CDC ranked 189th out of 222 agencies in worker morale.

[14] For his statement (August 3, 2008) on the report by the U.S. Centers for Disease Control and Prevention (CDC) that there were 40% more new HIV infections in the United States than previously estimated, go to: http://www.johnmccain.com/Informing/News/PressReleases/bfcf096e-e9be-453f-b6b6-49cdee396a74.htm.

[15] On July 30, PEPFAR was reauthorized at $48 billion through 2013, but it remains to be seen how much funding will actually be appropriated each year. The legislation also removed the provision that required one third of the plan's prevention funding to be spent on abstinence and fidelity programs.

[16] U.S. funding for global public health has been neglecting the most vital needs such as maternal and child health and family planning. A recent article in *The Lancet* analyzes McCain and Obama positions on global health and finds reason to believe that Obama would re-balance U.S. support. See Nellie Bristol, "Obama *vs* McCain on global health, *The Lancet* 2008; 372:521-522 (16 August 2008):

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What Health Care System?

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Dr. David Satcher, former U.S. Surgeon General and a member of the CSDH, said: "New Orleans and its experience with Hurricane Katrina illustrate why we need to target social determinants of health – including housing, education, working and learning conditions, and whether people are exposed to toxins – better than any place I can think of right now."

[1] Donald W. Light, "Fostering a Justice-Based Health Care System." *Contemporary Sociology*, Vol. 29, No. 1 (Jan. 2000), pp. 62-74. [2] Ibid, p.62.

[3] *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. (WHO, August 2008). Accessible at: http://www.who.int/social_determinants/final_report/en/index.html.

[4] Professor Marmot is head of the epidemiology and public health department at University College, London. He has been selected to be the Keynote Speaker at the American Public Health Association's Annual Meeting and Conference in San Diego in October.

[5] For definitions of its key concepts, see: http://www.who.int/social_determinants/final_report/key_concepts/en/index.html. [6] Recommendation #14.3.

[7] It contrasts this to the 176,633 lives saved in the U.S. by medical advances in the same period.

Comparative Health Expenditures, Resourses , Service Use
Organisation for Economic Co-operation and Development Countries
2005 - 2006

Country	Total Health Spending (% GDP) (2006)	Total Spending Per Capita (US$ Parity) (2006)	Public Spending/ % of Total Spending) (2006)	Practicing MDs/ 1,000 (2006)	Practicing Nurses/ 1,000 (2006)	Acute Care Hospital Beds/ 1 000 (2006)	MRI CT Scanners/ Million (2006)		Hospital Discharges/ 100,000 (2005)	Hospital Acute Care ALOS (Days, 2005)	Infant Deaths/ 1,000 Live Births (2005)	CABG Surgeries/ 100,000 (in-patient) (2004)	PCI Procedures (Inpatient)/ 100,000 (2004)
Australia							4.9		16,220	6.0	5.0	72.3	163.4
Austria	10.1	$ 3,606	76.2	3.6	7.3	6.1	16.8	29.8	27,765	5.9	4.2	53.7	
Belgium	10.4	$ 3,488		4.0		4.3	7.1	39.8	17,429	7.7	3.7	152.1	421.8
Canada	10.0	$ 3,678	70.4	2.1	8.8		6.2	12.0	8,716	7.2	5.4	91.4	137.5
Czech Republic	6.8	$ 1,490	87.9	3.6	8.1	5.4	3.8	13.1	21,073	8.0	3.4	84.5	
Denmark	9.5	$ 3,349			15.3			15.8	17,013	3.5	4.4	96.3	181.6
Finland	8.2	$ 2,668	76.0	2.7	8.3	3.1	15.2	14.8	20,131	4.8	3.0	65.9	121.1
France	11.1	$ 3,449	79.7	3.4	7.6	3.7	5.3	10.0	27,924	5.4	3.8		
Germany	10.6	$ 3,371	76.9	3.5	9.8	6.2	7.7	16.7	20,035	8.7	3.9	86.5	301.6
Hungary	8.3	$ 1,504	70.9	3.0	6.1	5.5	2.6	7.2	25,623	6.3	6.2	137.8	254.0
Iceland	9.1	$ 3,340	82.0	3.7	13.7		19.7	26.3	17,244	5.4	2.3	56.4	190.0
Ireland	7.5	$ 3,082	78.3	2.9	15.4		9.7	12.8	13,669	6.6	4.0	38.9	177.9
Italy	9.0	$ 2,614	77.2	3.7	7.1	3.3			14,091	6.7		87.4	315.1
Japan				2.1	9.3	8.2			10,550	19.8	2.8		
Korea	6.4	$ 1,480	55.1	1.7	4.0	6.8	13.6	33.7	13,216			5.9	
Luxembourg	7.3	$ 4,303	90.9	2.8	16.0	4.6	10.9	28.3	17,327	7.3	2.6	68.8	199.6
Mexico	6.6	$ 794	44.2	1.9	2.3	1.0	1.4	3.6	5,241	4.0	18.8	2.3	1.6
Netherlands	9.3	$ 3,391		3.8	8.6	3.0			10,414	6.8	4.9	58.2	
Norway	8.7	$ 4,520	83.6	3.7	31.6	3.0			17,519	5.2	3.1	88.5	231.8
Poland	6.2	$ 910	69.9	2.2	5.1	4.7	1.9	9.2	18,599	6.5	6.4	58.9	202.2
Portugal	10.2	$ 2,120	70.6				5.8	25.8	9,004	7.1	3.5	21.4	69.8
Spain	8.4	$ 2,458	71.2	3.6	7.3		8.8	13.9	10,780	6.7	3.8	29.5	183.0
Sweden	9.2	$ 3,202	81.7			2.2			16,052	4.6	2.4	60.9	158.3
Switzerland	11.3	$ 4,311	60.3	3.8		3.5	14.0	18.7	15,898	8.5	4.2	32.6	85.5
United Kingdom	8.4	$ 2,760	87.3	2.5	11.9	2.2	5.6	7.6	12,723	7.8	5.1	47.1	81.2
United States	15.3	$ 6,714	45.8	2.4	10.5	2.7	26.5	33.9	11,925	5.6	6.9	145.4	433.7

Source: OECD Health Data, 2008