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1st Quarter, 2007

Vol. XXIX, No. 1

# Health Planning

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the newsletter of the  
American Health Planning Association

## *President's Message*

### **The Primacy of Public Health**

by **John Steen**

Over 10 days in January, the *British Medical Journal* (*BMJ*) conducted a poll among its readers to determine what they thought is the most important medical advance since 1840, the year of its founding. From a list initially suggested by its readers, an expert panel chose the top 15, which formed the basis for the vote. *BMJ* also published a supplement in which experts argued the merits of each individual advance.

Among the 15, just four advances each received over 10 percent of the vote. They are:

|  |       |
|--|-------|
| Sanitation (clean water & sewage disposal) | 15.8% |
| Antibiotics                                | 14.5% |
| Anesthesia                                 | 13.9% |
| Vaccines                                   | 11.8% |

The knowledgeable readers of the *BMJ* who voted (11,341) include physicians (28.6%), members of the public (22.8%), students (14.2%), and academic researchers (10.2%) who live largely in the U.K. (37.7%) and the U.S. (20.0%). Once again, its readers find that public health is principally responsible for the advance of medicine in that sanitation and vaccines are

*Continued on page 2*

#### **Inside this issue:**

|                                |    |
|--------------------------------|----|
| COPN Metaphysics II            | 3  |
| State Health Planning Survey   | 5  |
| Health Care Reform in New York | 7  |
| Policy Perspective             | 9  |
| Job Bank                       | 13 |



## 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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## The Primacy of Public Health

*Continued from page 1*

public health's province, while antibiotics are shared by public health and personal health care.

Here in the U.S., our media are full of articles about the need to improve health status, reduce racial and ethnic disparities, and reduce national health spending, with nary a one about the value of public health. It would seem that they should be addressing the need for public policy that gets at the root determinants of premature death and disability. In a now classic 1993 research article,<sup>1</sup> J. Michael McGinnis and William H. Foege related the ten leading diagnoses of death in the U.S. in 1990 to the actual causes of those deaths. They found that 50 percent of deaths were attributable to behavioral choices – as opposed to genetic and external factors – and therefore were potentially responsive to public health education and prevention interventions. The distribution of causes of death was found to be essentially the same 10 years later when assessed again by Mokdad and col-

### Leading Causes of Death in the U.S.

|                               | 1990    | 2000    |
|-------------------------------|---------|---------|
| Tobacco                       | 400,000 | 435,000 |
| Poor Diet & Physical Activity | 300,000 | 365,000 |
| Alcohol Consumption           | 100,000 | 85,000  |
| Microbial Agents              | 90,000  | 75,000  |
| Toxic Agents                  | 60,000  | 55,000  |
| Incidents Involving Firearms  | 35,000  | 29,000  |
| Sexual Behaviors              | 30,000  | 20,000  |
| Motor Vehicle Accidents       | 25,000  | 43,000  |
| Illicit Use of Drugs          | 20,000  | 17,000  |

leagues in 2000,<sup>2</sup> as is shown in the box above. In 2000, tobacco was the cause of 18.1% of U.S. deaths and poor diet and physical activity was the cause of 15.2%.

Since 1900, the average life expectancy for Americans has increased by about 30 years. Over twenty-five of the 30 years can be attributed to public health initiatives, whereas medical advances account for less than 4 years.<sup>3</sup> How bizarre it is that U.S. health care expenditures total nearly \$7,000 annually for every man, woman and child, whereas in 2005, federal support for CDC was roughly \$25 per person per year, and state support for public health averaged \$35 per person.

Public health's top ten achievements in the 20<sup>th</sup> Century<sup>4</sup> include:

- Vaccinations
- Motor vehicle safety
- Safer work places
- Control of infectious diseases
- Decline in coronary heart disease and stroke deaths
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

So what are the factors that influence health status? Here they are<sup>5</sup>:

|                        |                      |
|------------------------|----------------------|
| Health Behaviors - 50% | Environment - 20%    |
| Genetics - 20%         | Access to Care - 10% |

And all of these factors assume that an infant has survived its first year of life, but the U.S. rate for infant mortality is among the worst of all large industrialized nations. Among 33 industrialized nations, the U.S. is tied with Hungary, Malta, Poland and Slovakia with a death rate of nearly 5

*Continued on page 6*

## CON Metaphysics II

Dean Montgomery

It is often said that the market for bad ideas never closes. This certainly appears to be true for certificate of need (CON) program categorization schemes. An earlier commentary in this space explored one such scheme, the categorization and “analysis” of programs according to their level of regulatory “stringency.”<sup>1</sup>

Perhaps even more problematic than the irony-riddled stringency categorization scheme is the fanciful exercise of “ranking” programs according to the number of services covered and the capital expenditure thresholds used. Where stringency categorization can be seen as merely arbitrary and conjectural, the pretentious precision of ranking individual states steps, intentionally or otherwise, into wonderland, where, to paraphrase Humpty Dumpty, a term or calculation means just what the author chooses it to mean, “neither more nor less.”

Unfortunately, AHPA and its agents led the trip down this yellow brick road. Between 1996 and 2005 AHPA’s *National Directory of Health Planning, Policy and Regulatory Agencies* contained a chart titled “Relative Scope and Reviewability [sic] Thresholds of CON Regulated Services.” That chart, and an accompanying map showing states coded according to the “weighted range” of services subject to review, listed state CON programs in rank order according to their regulatory scope and depth.<sup>2</sup>

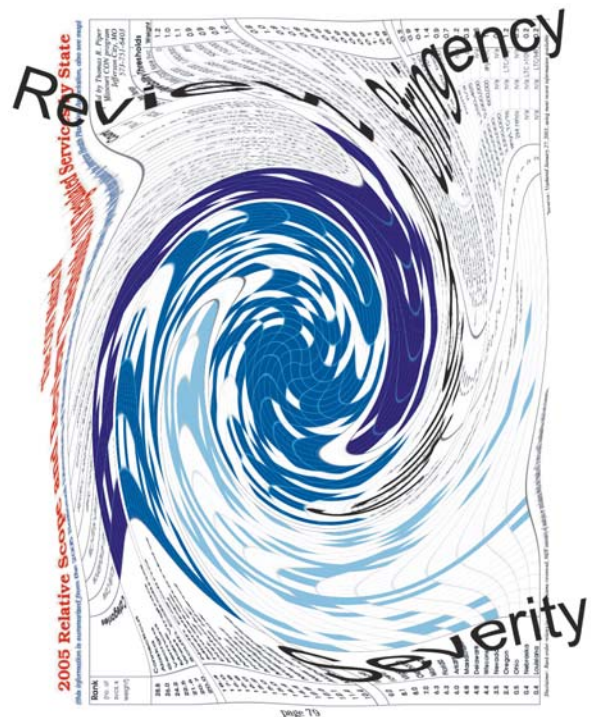
Largely ignored initially, with repetition the rankings soon began to generate interest and inquiries. Some appear to have taken the rankings at face value, accepting them as a quantitatively based analytical representation of the “relative” range and rigor of state CON programs. Others were more skeptical, inquiring about the factors, formulae, and methods used to generate the rankings and to differentiate state programs. By 2003, the rankings chart, commonly referred to as the state “CON matrix,” began to appear frequently in publications and news accounts critical of planning and CON regulation and, inexplicably, to be used in academic analysis and work.

With these developments and growing concerns about the rankings, AHPA initiated an examination of the analytical basis for them in 2005. The results were disconcerting. No credible basis for the rankings could be

identified or inferred. It became evident that the rankings were not only without meaningful foundation, but also were subject to misuse in ways that undermine planning and regulation. Moreover, as with the earlier “stringency” categorization that appears to have inspired their development,<sup>3</sup> the rankings appeared to be contributing, albeit inadvertently, to the debasement of academic standards and inquiry.<sup>4</sup> Accordingly, the indexed chart, the associated map, and all references to rankings were removed from AHPA’s *National Directory* beginning with the 2006 edition. They were replaced with a straightforward presentation of program specific data.

These corrective actions notwithstanding, the CON matrix is still in circulation and use by some. Major problems identified with the rankings, of which the reader should be aware, include:

- Lack of transparency. Although much can be inferred, neither the rationale for the rankings nor the methods (or logic) used to generate the



Continued on page 4

## CON Metaphysics II

Continued from page 3

“weights” used in the calculations is explained. The methodology is neither transparent nor self-evident and, hence, cannot be replicated or otherwise tested.<sup>5</sup>

- *Imprecise language.* The use of undefined, nonstandard terms and phrases such as “reviewability thresholds,” “severity of analysis,” “weighted range,” and “volume of items” obscures meaning and makes consistent interpretation of the data unlikely.
- *Idiosyncratic rankings.* Each state’s rank is a function of number of services/facilities/technologies regulated multiplied by a “weight” assigned to the state. The weight is a construct: a “relative” numerical value developed from the capital expenditure review thresholds for the facility, medical equipment, and new services subject to review in the state. There is no necessary or analytically meaningful connection between the number of services subject to review in a state and the “relative” capital expenditure review thresholds used in that state. Consequently, multiplying these two factors to produce an index or ranking necessarily yields idiosyncratic results.<sup>6</sup>
- *Mercurial weights.* The weights assigned each state give equal value to all services and facilities subject to review. Development of a new hospital, for example, is given the same weight as the purchase of a CT scanner, or the establishment of a hospice or home health service. As used, the weights have no meaningful discriminatory power. They are as likely to mask significant regulatory differences as to reflect them.
- *Inconsistent, subjective application of weights.* There is considerable variation in the regulatory language used by states to define and otherwise describe the facilities, equipment, and services subject to CON regulation. Some states enumerate a list of services and equipment subject to review regardless of capital cost. Others set separate capital expenditure limits (review thresholds) for facilities, equipment, and services. Many use a combination of review thresholds and a list of equipment and services subject to review. Consequently, assigning a “weight” for state coverage of new

services under CON is in many circumstances necessarily subjective, resulting in more or less arbitrary weight assignments. The use of an admixture of quantitative values and undefined terms such as “not applicable,” “any,” and “any clinical” illustrates the problem.

- *Discordant results.* As might be expected, the state rankings produced using this scheme are not credible. There is no evidence or reason to believe that Massachusetts, Michigan, New York, and Rhode Island, for example, should be ranked lower than Alaska, the District of Columbia, Mississippi, or Vermont. Yet that is the consistent pattern shown in the rankings. Empirical evidence is to the contrary.
- *Political naiveté.* Even if the methods used were intellectually defensible and the rankings produced were generally consistent with experience, ranking states in terms of their putative regulatory rigor or strength is inherently politically foolhardy. Whatever their merit, the rankings give opponents of CON regulation, of which there are many in all states, a convenient, presumptively analytical tool to attack highly ranked programs. This often prompts state officials to try to reduce the regulatory scope of the program. This pattern has been evident for a number of years. Intended or otherwise, such schemes necessarily generate powerful forces that result in a downward spiral in coverage and program integrity.

As with the “level of stringency” categorization, there is no merit to the individual state rankings. Both “methods” are inherently subjective, arbitrary, and lacking in analytical rigor.

Experience suggests that, however intriguing or amusing, the cost of snake oil is invariably high. Gresham’s law posits that “bad money” drives “good money” out of circulation.<sup>7</sup> Unchecked, debasement of the currency undermines the economy. This phenomenon—the counterfeit first debasing and then replacing value—appears to apply to the schemes that invite invidious comparison and categorization of state planning and CON programs. These benighted schemes may have helped drive fact, reason, and objective analysis from the market. We should be better prepared to challenge nonsense when and where it appears. The music man is always coming to town.

Continued on page 12

# State Health Planning Survey

By William J. Waters, Jr, and Stephanie Kissam<sup>1</sup>

In the Spring of 2006, the Rhode Island General Assembly passed the “Coordinated Health Planning Act,” calling upon the Director of Health in consultation with a representative advisory committee “to develop an assessment of the existing state capacity and authority to perform coordinated statewide health planning” and to study “an expanded role for the department of health in health care planning, including capital investment expansion and introduction of technology.”<sup>2</sup> In the fall of 2006, the Rhode Island Department of Health, in conjunction with the American Health Planning Association, conducted a web-based survey of all 50 states to determine the current organization and practice of health planning in the states.

Nineteen (38%) of the states responded to this survey. Eleven (22%) of the states indicated that they have a single state agency that is responsible for producing a statewide health services plan. All of these 11 states report to the AHPA that they have a “Statewide Health Plan” and/or a “Health/Medical Plan,” and that they do have active Certificate of Need (CON) programs as well.<sup>3</sup> The highlights of the survey responses are as follows, based on the modal response of the 11 states (the actual response rate ranges from 6 to 10 on specific questions): :

- 5 state health-planning agencies are located in Departments of Health or Public Health;
- 7 state health-planning agencies had budgets in the range of \$250,000 to \$750,000;
- State revenue is the main source of revenue (54% of the revenue) for these states;
- Most of the revenue (73%) is used for State employee staff;
- 4 of the states have health planning advisory bodies, 4 do not;
- 7 states have state statutes mandating the scope of the statewide health services plan;
- 5 states do not address health care professionals in their state’s health services plan;
- 6 states address nursing homes and 5 states address hospitals in their state’s health services plan;
- 4 states address gamma knives and 4 states address PET scanners in their state’s health services plan;
- 5 states address cardiac catheterization and 5

states address open-heart surgery in their state’s health services plan;

- 4 states coordinate other state agencies’ plans to develop health care services;
- In 5 states, the health services planning staff also undertake Certificate of Need activities;
- 6 states indicate that the main customers of their state’s health services plan are health care facilities;
- None of the states indicate a “high impact” of health services planning on health care cost trends in their state; 4 states indicate “some impact.”

## Conclusions

Given the low response rates to this survey, it is not possible to draw any definitive conclusions. However, the following insights seem justified.

There has been a substantial diminution in health services planning at the state level since the demise in the 1980s of federal funding for state health planning. Under three successive programs of federal financial support of health planning (Hill-Burton, Comprehensive Health Planning, National Health Planning & Resources Development Act) from 1945 to the mid 1980s, virtually all of the states had significant health services planning operations.<sup>4</sup> It would appear that most states have not sustained health services planning in the absence of federal financial support. However, at least 10 states have sustained a health services planning operation at the state level. These states appear to be concentrating on traditional health care facilities and equipment issues directly related to the CON process.

While not directly addressed by this survey, it is known that almost all of the states produce Healthy People/Health Improvement plans in conjunction with the national Healthy People initiative.<sup>5</sup> The Healthy People planning process concentrates on the reduction of risk factors adverse to positive health outcomes. Thus, it would appear that health planning for health promotion is stronger at the state level than health planning for personal health services delivery. This observation seems consistent with the findings of the AHPA, which reported in 2006 that 33 states had a “Statewide Health

*Continued on page 12*

## The Primacy of Public Health

Continued from page 2

per 1,000 babies. That is primarily a reflection of barriers to prenatal care and maternal health, a consequence of our lack of universal health care, and of racial and income healthcare disparities. Among U.S. blacks, there are 9 deaths per 1,000 live births, closer to rates in developing nations than to those in the industrialized world.

### Public Health Is the Answer, Just Ask the Right Question

What we need is basic primary and preventive healthcare services, but we do not have a delivery system that is designed to provide primary prevention. We don't even have one that has been designed at all, just co-opted and driven by profitmaking, but there is no profit for business in prevention, just for people. That is what public health does, and it is uniquely a government function.<sup>6</sup> Our poor health rankings are pointed testimony to its underappreciation and underfunding. It is the misfortune of public health that its greatest benefits are invisible. While it protects everyone against maladies unimagined today, its detractors are able to criticize it with impunity.<sup>7</sup>

*I can think of no more stirring symbol of man's humanity to man than a fire engine.*

*- Kurt Vonnegut*

That was not always so, but we forget. The mistrust of government clouds public health in its role of primary prevention, but that view is only a generation old. Before the advent of good sanitation and vaccines, plagues were feared far more than cancer is today, and childhood was something more to be survived than enjoyed. In 1796, when Edward Jenner first successfully immunized a child against smallpox, it was the world's deadliest infectious disease. For the next century and a half, medicine and public health systematically eradicated all those deadly childhood diseases save one, polio. The Salk vaccine (1955) was both the triumph of this process and its last effective publicity. A generation later, we had already become used to the luxury of our ignorance, that luxury guaranteed by public health. And the fastest growing sector of the health care industry thrives in the shadow of that ignorance, offering its sham procedures and cures as wish fulfillment for those age-old yearnings of mankind continually being addressed practically by public health. Today, it would take a vaccine against all cancers, a newly virulent smallpox, or the Ebola or Marburg viruses to remind us how to be grateful for primary prevention.<sup>8</sup>

## Public Health in the 21<sup>st</sup> Century: A Better Society

What would it take to get us to see that our best interest is served by strong support for public health? What would it take to get us to see that our support for the highest standards for education are far more fundamental ... to everything? A recent research article<sup>9</sup> looked at vital statistics data for 1996-2002 in order to determine the number of averted deaths attributable to medical advances and the number of deaths that would have been averted if adults with lesser education had experienced the mortality rates of college-educated adults. The result: medical advances prevented 178,193 deaths, whereas giving all adults the death rate of those with a college education would have saved eight times as many, 1,369,335 lives. "On the basis of how many lives can be saved, our data suggest that efforts to correct the social conditions causing education-associated excess mortality should be proportionately greater than society's investment in medical advances," the authors said, concluding: "Formidable efforts at social change would be necessary to eliminate disparities, but the changes would save more lives than would society's current heavy investment in medical advances. Spending large sums of money on such advances at the expense of social change may be jeopardizing public health."

<sup>1</sup>J.M. McGinnis and W.H. Foege, "Actual causes of death in the United States," *JAMA*. 1993;270:2207-2212. [Abstract](#).

<sup>2</sup>A, H, Mokdad et al., "Actual causes of death in the United States," 2000. *JAMA*. 2004;291:1238-1245. [Abstract](#)

<sup>3</sup>B.J. Turnock, *Public Health: What it is and How it Works*, 3rd Edition. (Jones and Bartlett Publishers, 2004).

<sup>4</sup>CDC. "Ten Great Public Health Achievements—United States, 1900–1999." *Morbidity and Mortality Weekly Report* 48 (1999): 241–243.

<sup>5</sup>CDC & the University of California, Institute for the Future, 2000.

<sup>6</sup>In its *World Health Report 2000*, the WHO asserted that governments should be the "stewards of their national resources, maintaining and improving them for the benefits of their populations. In health, this means being ultimately responsible for the careful management of their citizens' well-being."

<sup>7</sup>Nevertheless, in a Harris Poll online survey in mid-January, 90% said they know what the CDC does, and 84% gave it positive marks, the highest performance marks among 13 federal agencies they were asked to rate.

<sup>8</sup>Information on National Public Health Week 2007 may be found at <http://www.nphw.org>, which offers an overview of what public health can do. It is what should be publicized throughout the year, not just during the first week of April.

<sup>9</sup>Steven H. Woolf et al., "Giving Everyone the Health of the Educated: An Examination of Whether Social Change Would Save More Lives Than Would Medical Advances," *American Journal of Public Health*, Feb 2007. ♠

# Health Care Reform in New York Looking Forward and Looking Back

By John Steen

Prior to being elected Governor of New York, Eliot Spitzer served for eight years as the state's Attorney General, winning national recognition for landmark cases protecting investors, consumers, the environment, and low-wage workers. Any doubt about his continued dedication to the public interest was removed on January 26 in a speech he delivered at the Rockefeller Institute of Government entitled "An Agenda To Fundamentally Reform New York's Health Care System."<sup>1</sup> In it, he defined "reform" as restoring to government its proper functions in protecting its citizens, and his judgment about the last 12 years in the State was pointed: "Government abdicated its responsibility to set standards, demand results and hold institutions receiving billions in state tax dollars accountable to the State and to the people those institutions serve."

About the New York State Commission on Health Care Facilities in the 21<sup>st</sup> Century,<sup>2</sup> he had this to say: "This was a process that should never have been necessary in the first place.... Now we face dramatic instead of gradual change to rationalize a system in desperate need of reform." He continued: "For too long, we have financed the health care system we have, not the health care system we need. So we're left pumping billions of dollars into a broken system with no deliverables and no accountability."

He went on to insist that the State's health care system must once again be made accountable to its people, that it must be patient-first, and that "no patient-first health care strategy can be complete without a comprehensive effort to address public health ... that targets primary and preventive care – resources that will go to support programs that decrease obesity rates and increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visits, and public health education on the quality of mammograms and other important issues."

## Health Commissioner Par Excellence

In hearing his speech, I was reminded of Dr. David Axelrod, whose innovative policies as New York

State's Health Commissioner for 12 years (1979-91), motivated by his imperative of patient protection, became models for the nation in the 1980s and 1990s. In a February 1991 editorial, shortly after he suffered an incapacitating stroke, *The New York Times* wrote that, "In a job that all too often reflects the narrow interests of the medical profession and its institutions, Dr. Axelrod saw the state's whole population as his patient. He treated it with uncommon compassion, vision and courage."



His pioneering policies, which ranged from stringent regulation of doctors and hospitals to universal health insurance (UHI),<sup>3</sup> anti-smoking legislation, and unbending protection of the confidentiality of AIDS patients and funding for AIDS research, were supported by then Governor Mario M. Cuomo. Cuomo's active support enabled him to earn a reputation, unique among health commissioners, for taking on vested interests in the State's medical-industrial complex. In 1987, he used the State's hospital rate-setting program to realign reimbursement toward the provision of primary care by community clinics.

## The Pataki Era

In 1995, Governor George Pataki took office and immediately began to dismantle the State Health Department's resources and role in policy leadership.<sup>4</sup> Also in that year, he captured the revenue stream that had been funding the state's eight health systems agencies and constituting about half of their budgets since the cessation of federal funding in 1986, diverting it into the state's general fund. (Today only the ones in Rochester and Syracuse survive as smaller community-supported agencies.) At the time, state officials' explanation was that the growth of "free market forces" such as health maintenance organizations and managed-care plans had rendered much of the tradi-

*Continued on page 8*

## Health Care Reform in New York

Continued from page 7

tional review and approval process obsolete. Consumer and community groups saw their demise as the stifling of forums for their input, ensuring that provider initiatives would remain unknown and unchallenged. That was confirmed in 1996 when Pataki appointed 14 new members to the State Hospital Review and Planning Council, the state's CON review body, to replace 16 whose terms had expired, eight of whom were consumers. Just one of the new appointees was a consumer, and contrary to the Council's authorizing legislation, none was an HSA representative. That was widely seen as payback for the Council's rejection in 1995 of a series of hospital "regulatory reforms" proposed by the Pataki administration.<sup>5</sup> Also in 1996, the administration got the legislature to eliminate the state's hospital rate-setting program.

### Health Care Reform & the Institutionalization of Civic Life

So Spitzer's challenge will be to recreate a Health Department befitting the State's history of leadership in public health, health planning, and health regulation. Dennis Whalen, who has been first deputy under a number of health commissioners, will be the deputy secretary for health, operating out of the Capitol, an arrangement that will provide his considerable experience and institutional memory in that effort.

And Dr. Axelrod's principled refusal to have the state's Medicaid administration within his health department will be honored through the new Office of Health Insurance Programs, which will assume control of Medicaid and the state's other insurance programs. He maintained the inherent conflict made it inappropriate. You can't regulate an industry and at the same be a major supplier of its funds.

In remembering the Axelrod-Cuomo era, I was also reminded of the Health Department's 1989-1992 proposal for UHI in the state, called UNY\*Care (for Universal New York Health Care), modeled after Medicare, and as promising a state UHI program and national model as any introduced since that time. It was not pursued once Governor Cuomo decided not to enter the Democratic primary for president, but its promise was as unique and as strong as its foundation in the state's history of fostering civic and community life through the institutions it created. In Spitzer's words, I could hear a return to the political ethos of the last half century of the state's governors and other elected officials, one founded on public life and an open public

process. UNY\*Care's chief designer, Deputy Commissioner Dan E. Beauchamp, expressed this point succinctly: "The point of health care reform is precisely to strengthen the public and its power vis-à-vis the health care system – to use policy to create a more populist and civic-centered system."<sup>6</sup> Once created, that system can then give life in the public mind to the policies that inspired it. Daniel Patrick Moynihan, the late senator from New York, explained it this way: "The central conservative truth is that it is culture, not politics that determines the success of a society. The central liberal truth is that politics can change a culture and save it from itself."<sup>7</sup>

Will this be the new governor's agenda too? If so, he faces an uphill battle against the legislature, and he will have to count on the public support he may get by making an open public process out of his battle. The last reform governor who did that was Theodore Roosevelt in 1899, and he proved successful.

Spitzer acquired much experience doing that as attorney general, and he explained his approach in an interview with *The New York Times* on February 8: "A status quo does not want itself revealed, whether it's to investors, shareholders or voters," he said. "It pushes back in a strenuous way. My response every time is, let's just get out the facts, what are we trying to do and why. And I have this very simple-minded belief that we will win by presenting those facts."

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<sup>1</sup>[http://www.ny.gov/governor/keydocs/0126071\\_speech.html](http://www.ny.gov/governor/keydocs/0126071_speech.html).

<sup>2</sup>For a description of its November 2006 Report, see "Policy Perspective" in the 4<sup>th</sup> Quarter 2006 *Health Planning Today*.

<sup>3</sup>During the Reagan years, he often found himself a lone figure among physicians in his advocacy, and in 1989 he proposed his own plan, UNY\*Care, that would have guaranteed basic health care to every resident of New York State.

<sup>4</sup>In 1989, Stuart H. Altman, the dean of the Florence Heller Graduate School for Social Policy at Brandeis University, stated that "New York hospitals are by far the most tightly regulated and most effectively regulated in the United States."

<sup>5</sup>Just three months after Pataki took office, the Governor's Office of Regulatory Reform announced "a 16-point plan to reduce onerous state regulations in the health-care field." It included:

- The Department of Health (DOH) will seek legislation to eliminate the Public Health Council from CON activities.
- DOH will amend CON regulations to permit the waiver of review requirements that are not relevant to particular

Continued on page 12

## Policy Perspective

By John Steen

### California and Pennsylvania

The states keep trying to be accountable for their residents' health care needs, but they lack the authority to implement the structural changes in health care delivery necessary to achieve their aims, and so they must deal with a market-driven system for which the rules are set nationally by the industries profiting from the market. And so each state comes up with its own plan that protects those industries, insurance key among them, and requires its own citizens to pay most of the costs. This despite numerous polls showing that a majority of Americans wish to have a universal single-payer system "like Medicare."

So, how to see what is going on in California? Well, just last August, the California legislature passed a true universal health care bill (SB 840) that would have created one state fund for all the health care Californians need. But Governor Schwarzenegger vetoed it to protect the role of private insurance companies, choosing instead to model his plan on that of Massachusetts. Credit him only with attempting to include everyone, even illegal immigrants, in his plan, and imposing community rating and an 85% minimum loss ratio (which already applies to HMOs in California) on insurance companies. In fact, his plan will likely cost the state's taxpayers an extra \$12 billion per year. SB 840 would save nearly that much per year!<sup>1</sup> It is comprehensive in its coverage, including full coverage for mental health, dental, vision, and prescription drugs. The governor's plan does not require employers to offer any minimum benefit. And it has \$7,500 out-of-pocket costs for individuals and \$10,000 out-of-pocket costs for families, while SB 840 has neither out-of-pocket costs nor deductibles. On February 27, State Senator Sheila Kuehl introduced the bill for the third time, but that's unlikely to be the charm, given the need for a two-thirds approval vote (for tax provisions to fund it) in the legislature.

In Pennsylvania, Governor Rendell announced a plan similar to those already enacted in Maine and Vermont. His plan would, if legislatively approved, go well beyond providing universal health insurance. It too employs a limited form of community rating and an 85% floor on loss ratios for small group plans, but otherwise would protect the insurance industry and, unlike Massachusetts and California plans, would not

mandate purchase of health insurance by all its residents. Its 47 initiatives include new laws and regulations addressing quality of care and cost containment that will require legislative enactment and federal endorsement. Most provocatively, a system of regional boards composed of volunteer representatives from academia, health care, and business and insurance groups would be created to oversee the review of spending projects at hospitals to ensure that expansions or major equipment purchases were necessary.<sup>2</sup> The governor said in the future the state intends to stop paying hospitals for treatment stemming from medical errors or preventable complications. Pennsylvania's legislature considered legislation last year for a statewide single-payer plan that wasn't acted upon, but will be introduced again this year.

All these state efforts may be moot if, as in Maryland, federal courts find their employer mandates to be inconsistent with ERISA's preemption of employer funded plans.

### The ACP on "Health Care Reform"

In January, the American College of Physicians (ACP), which represents 120,000 internal medicine physicians and medical students, issued a proposal to place internists and family doctors at the center of patient care, where they could provide the coordination and oversight that has been missing in U.S. health care. "Expanding health insurance is essential. But it is equally essential that we reform the way that care is organized, financed and delivered in the United States," said Dr. Lynne Kirk, the group's president. And Robert Doherty, who manages government affairs and public policy for the ACP, said "It's being done successfully in other countries," pointing to Commonwealth Fund studies<sup>3</sup> as evidence that health care quality in the U.S. often falls short of that seen in countries with nationalized programs, such as Britain, New Zealand and Australia. In the U.S., the Department of Veterans Affairs used this model with success, Doherty said.

The ACP report on this proposal identifies primary-care-oriented countries with nationalized systems as "consistently associated with better health outcomes, lower costs, and greater equity in care," and it states that, "the United States rates the poorest on all aspects

*Continued on page 10*

## Policy Perspective

Continued from page 9

of experienced care, including access, person-focused care over time, unnecessary tests, polypharmacy, adverse effects, and rating of medical care received.”<sup>4</sup> In January 2006, the ACP reported that the U.S. is facing a collapse of primary care medicine.

An excellent set of observations and recommendations, but I wonder, does the ACP really now favor the model they've cited: nations in which health care is mission-directed, not profit-directed, and physicians work on government salaries, i.e., socialized medicine? For example, in socialized countries like the U.K. and Sweden, the ratio of a physician's income to that of the average worker is 1.4 and 1.5, respectively. In Canada, which has a single-payer reimbursement system for physicians, the ratio is 3.2. In the U.S., it is 5.5. If we were to restore ethical medical practice here, we might once again have the kind of physicians we once had.

*“The pricing practices of the medical industry depart sharply from the competitive norm.... It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business men in general. These expectations are relevant because medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it, and there is an element of trust in the relation. But the ethically understood restrictions on the activities of a physician are much more severe than on those of, say, a barber. His behavior is supposed to be governed by a concern for the customer's welfare, which would not be expected of a salesman.”*

-Kenneth Arrow, 1972 Nobel Prize in Economics winner<sup>5</sup>

## Updated Quality Indicators

State health regulators will wish to take note of the January 2007 updating of quality indicators issued by the Agency for Healthcare Research and Quality (AHRQ). The ones they will find most relevant to their state health plans, licensure, and CON criteria are those covering coronary artery bypass graft (CABG) volume and mortality rates, percutaneous coronary transluminal angioplasty (PTCA) volume and mortality rates, and bilateral cardiac catheterization rates (see box, below). Quality measures are also essential as a basis for limiting the capacity of services and equipment, and a 1999 *JAMA* article well documents the harm resulting from over utilization (see box below).

And the American Public Health Association has a new searchable Health Disparities Database containing projects and interventions aimed at the challenges presented in trying to improve the quality of health care and increasing the health literacy of the poor and of racial and ethnic groups and other underserved communities. It covers creating tools/assessments/audits to improve health care, creating private/public partnerships to fix health care disparities, and creating healthy communities by ensuring adequate infrastructure and resources. (Again, see box, below)

## Is Urban Health Care Endangered?

Observers have increasingly been noting the boom in new hospital construction in affluent suburban areas while inner city hospitals are closing. As hospital construction costs escalate, hospitals must secure an ever higher proportion of well-paying patients in order to make that construction financially feasible. A 2005 study in the *New England Journal of Medicine* found

Continued on page 11

### See, for information on ...

... **CABG volume:** [http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc\\_id=8869](http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc_id=8869)

... **CABG mortality rate:** [http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8875](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8875)

... **PTCA volume:** [http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8870](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8870)

... **PTCA mortality rate:** [http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8876](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8876)

... **Bilateral Cardiac Catheterization rate:**

[http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc\\_id=8893](http://www.qualitymeasures.ahrq.gov:80/summary/summary.aspx?ss=1&doc_id=8893)

... **Area rates & other quality indicators:** AHRQ's *Guide to Inpatient Quality Indicators: Quality of Care in Hospitals – Volume, Mortality, and Utilization* (February 20, 2006) at [http://www.qualityindicators.ahrq.gov/downloads/iqui/iqui\\_guide\\_v30.pdf](http://www.qualityindicators.ahrq.gov/downloads/iqui/iqui_guide_v30.pdf). Indicators for 55 specialized surgical procedures: <http://www.qualityindicators.ahrq.gov>.

... **Quality measures:** <http://www.dartmouth.edu/~cecs/downloads/jsc80266.pdf>

... **Health disparities:** <http://www.apha.org/programs/disparitiesdb/>.

## Policy Perspective

Continued from page 10

that 16 percent of city-based public hospitals were lost between 1996 and 2002. Meanwhile, President Bush's proposal to reduce the rate of growth in Medicare and Medicaid spending has the potential to severely strain hospitals that serve large numbers of poor and uninsured patients. Medicare spending would grow at an annual rate of 6.7 percent, rather than 7.4 percent, if there were no downward adjustment.

For these and related reasons, state regulators are challenged to find ways of maintaining a full-range of adequate hospital services in urban areas, and regionalization of specialized services in major urban centers with sufficient volume is a win-win situation for the public interest in such areas. It can at once both improve outcomes and enhance revenues for the urban centers. But what about rural hospitals? A recent study in New York State looked at what will happen to smaller rural hospitals if patients needing "high-risk" operations are transferred or directed to larger medical centers. Small hospitals were defined as less than 50 beds, and high-risk operations included 6 procedures for which there is a documented volume-outcomes association: abdominal aortic aneurysm repair, carotid endarterectomy, colectomy, cystectomy, esophagectomy, and pancreatotomy. Estimated average contribution to hospital net revenue for all procedures was approximately 2 percent, nearly all attributable to colectomy. The study authors concluded that small rural hospitals would not experience an unsustainable economic loss with a shift of high-risk operations to larger hospitals.

### Specialty Hospitals

Regulators have been suitably critical of the establishment of specialty or "boutique" hospitals as selectively treating lower risk patients, raising concerns about patient safety and quality issues compared to general hospitals due to specialty hospitals' lacking full emergency departments, their impact on the revenues of general community hospitals, and their effects on service utilization with its cost implications. A recent observational study of outcomes showed that Medicare patients who underwent coronary revascularization procedures at specialty hospitals had no outcome advantage over those treated at general hospitals, after adjustment for patient characteristics and hospital procedure volumes, and several studies have documented the validity of all of the concerns save for the last. Now an article in *JAMA* shows the cogency of the last concern.<sup>7</sup>

It highlights the effects within specialty-hospital regions of physician financial incentives and growth in procedure rates at nonspecialty hospitals due to new competition.

The authors analyzed 1995-2003 data on Medicare beneficiaries in three types of hospital referral regions: 13 where new specialty cardiac hospitals opened during that period, 142 where new cardiac programs opened at general hospitals, and 151 where no new cardiac programs started. Rates of both CABG and percutaneous coronary intervention were statistically similar in 1995 in the three types of regions. From 1995 to 2003, the rate of total revascularizations grew significantly more in regions with newly opened specialty cardiac hospitals than in the others. Within 4 years after they opened, the relative increase in revascularization procedures within their regions was 19.2%, compared with 6.5% and 7.4% in each of the other two types of regions. This significant difference was reflected in both the relative decline in CABG over time (-4% in regions with new specialty cardiac hospitals vs. about -19% in the other regions) and in the relative increase in PCI (+35% vs. +23%); the latter was due entirely to PCI in non-emergency patients without acute myocardial infarction (+42% vs. +24%).

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<sup>1</sup>See the Lewin Group analysis at <http://singlepavernow.net/sb840/summary.pdf>.

<sup>2</sup>Maine's 2003 plan included a greater cost containment role for CON through the imposition of a state spending cap against which applications are reviewed.

<sup>3</sup>See "U.S. Rankings on an International Report Card," *Health Planning Today*, 4<sup>th</sup> Quarter, 2006, pp.7-8

<sup>4</sup>*A System in Need of Change: Restructuring Federal Health Care Policy To Make Patient-Centered Care Available to All*, p. 6, accessible at [http://www.acponline.org/hpp/statehc07\\_1.pdf](http://www.acponline.org/hpp/statehc07_1.pdf)

<sup>5</sup>"Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review*, 53 (5), December 1963, 949-950.

<sup>6</sup>A.R. Chappel et al., "Small Rural Hospitals and High-Risk Operations: How Would Regionalization Affect Surgical Volume and Hospital Revenue?" *J Am Coll Surg*. 2006;203(5):599-604. Only 14 small hospitals were included in the study, which covered the years 1998-2001.

<sup>7</sup>Brahmajee K. Nallamothe et al., "Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries," *JAMA*, 2007;297:962-968. <http://jama.ama-assn.org/cgi/content/abstract/297/9/962> ♦



## State Health Planning Survey

Continued from page 5

Plan,” 11 states had a “Health/Medical Plan”, 12 states had a “Specific Service Plan,” and 15 states had none of these plan types.<sup>6</sup>

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<sup>2</sup>Rhode Island Coordinated Health Planning Act of 2006, S 2757 Substitute A as Amended, H 7424 Substitute A as Amended.

<sup>3</sup>American Health Planning Association, *National Directory: State Certificate of Need Programs, Health Planning Agencies*, 2006.

<sup>4</sup>Hospital Survey & Construction Act, PL 79-725, 1946; Comprehensive Health Planning Act, PL89-749, 1966; National Health Planning & Resources Development Act, PL 93-641, 1975, as amended.

<sup>5</sup>Healthy People, [www.healthypeople.gov](http://www.healthypeople.gov)

<sup>6</sup>American Health Planning Association, *ibid.* ♦



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## CON Metaphysics II

Continued from page 4

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<sup>1</sup>As used by a number of critics and consultants, “stringency” is seen as a proxy measure of regulatory rigor and effectiveness. See “CON Metaphysics I” *Health Planning TODAY*, XXIX.1, January 2007, p. 3.

<sup>2</sup>See *National Directory of Health Planning, Policy and Regulatory Agencies, Editions 7-16*, AHPA, 1996-2005.

<sup>3</sup>There is no direct reference to the “stringency” categorization scheme, but the two approaches have much in common. They use similar language and both group CON states in three broad categories. Unlike the broad stringency ranking scheme of 1, 2 and 3, the state specific rankings are arrayed in three groups with individual state rankings of 0.2 to 10.0, 10.1 to 20.0, and >20.0. There is no direct correlation between the three stringency classifications and the three state groups in the chart. The stringency categorization preceded the state rankings by several years.

<sup>4</sup>By early 2005, several graduate students were trying to use the CON program ranking data in both descriptive and analytic studies, including regression analyses. Steps were taken to discourage such use.

## Health Care Reform in New York

Continued from page 8

- applications – HSA reviews, need determinations, financial feasibility findings, etc.
- DOH will begin a review of all other CON requirements to identify those that can be eliminated, amended or streamlined.
  - Not-for-profit hospitals are required by statute to file an annual report that reviews the hospital's mission statement, incorporates the views of the communities served by the hospital on the hospital's performance and service priorities, and the hospital's commitment to meeting the needs of the community. We will work for the repeal of this statute.
  - NYS regulations for emergency departments are more prescriptive than the federal requirements, particularly regarding staff education and experience.... DOH will assess how the current requirements can be streamlined.

<sup>6</sup> *Health Care Reform and the Battle for the Body Politic* (Temple University Press, 1996), p.41, where Beauchamp wrote that, in their preoccupation with the distance between American political values and the values of a reformed health care system, social scientists “miss the point of the capacity of national health plans as institutions to change values and politics.” He also says (on p. 47) “that civic institutions such as national health plans – because of the patterns and ways of thinking they create in society – have a powerful way of creating their own politics, their own social reality.” One has only to consider the role that Medicare has played and plays to appreciate the validity of this point. The distance between our profit-driven market approach and the solidarity of Europe’s egalitarian system is accounted for primarily by their having long since institutionalized more definitive social insurance systems than ours.

<sup>7</sup>At the Godkin Lectures at Harvard in 1986. ♦

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<sup>5</sup>A disclaimer attached to the chart, which reads “Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions,” is enigmatic but inaccurate. It is not clear what is meant by “intensity of analysis” or “conclusions,” or how they could be based on “decisions” whatever their meaning. The statement is inaccurate however in that, contrary to the assertion, the rankings clearly are not based on the “volume of items reviewed,” but rather on the number of services covered and the capital expenditure weights assigned.

<sup>6</sup>There is no justification for the method used, but if one were to believe that there is some value or purpose to it, the calculations would need to be discrete. The medical facility capital expenditure would necessarily be related only to facilities subject to review, the medical equipment review threshold to the medical equipment subject to review, and the new service threshold to the new services subject to review.

<sup>7</sup>Gresham’s law, propounded by Thomas Gresham (1519-1579), financial advisor to Elizabeth I, holds that if two coins have the same nominal value but are made from metals of intrinsically unequal value, the cheaper will tend to drive the other out of circulation because the more valuable coin will be hoarded and not used in domestic transactions where the less valuable coin may be used.

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## Employment Opportunity

### SENIOR BUSINESS PLANNER

Novant Health

|                            |  |
|----------------------------|--|
| <p><i>Position</i></p>     | <p>Novant Health, one of North Carolina's largest employers, is a not-for-profit healthcare network of hospitals and related facilities that together meet the needs of over 3.5 million residents in the western part of the state.</p> <p>Currently, we seek a qualified professional to support regional strategic planning, development, and growth by providing strategic and business planning services. These will include new program feasibility assessment and development, strategic and business plan development, program enhancement, internal consultation and special project management. Additionally, you will assist with market research and analysis. We will also depend on you to manage multiple projects simultaneously and support the planning process comprehensively, from discussions of broad strategic concepts to decisions associated with development of concrete action plans.</p> |
| <p><i>Requirements</i></p> | <p>We seek the candidate who will be committed to understanding, meeting and exceeding customer needs and expectations. You must have a Master's degree (or equivalent experience) and three to five years work experience in strategic/business planning and development. Healthcare experience/knowledge is preferred. Your industry expertise must encompass current and future trends and applicable government regulations. Proficiency at relevant information systems/software, including spreadsheets and presentation software, is required, as is the ability to write in a clear, concise, and easily understood manner in report and presentation formats. Strong decision-making, project leadership and consultation skills are essential.</p>   |
| <p><i>Contact</i></p>      | <p>Novant Health offers competitive compensation and an excellent employee benefits package that includes flexible benefits, a retirement plan, on-site daycare/sick daycare, fitness facilities, educational funding, relocation assistance and much more.</p> <p>Please apply online at <a href="http://www.novanthealth.jobs">www.novanthealth.jobs</a>. We are an equal opportunity employer committed to diversity in the workplace.</p>  |



## Employment Opportunity

### DIRECTOR OF PLANNING

#### Elliot Health System

|                     |  |
|---------------------|--|
| <i>Position</i>     | <p>Elliot Health System in Manchester, New Hampshire, has retained Quick Leonard Kieffer to conduct a search for a Director of Planning.</p> <p>Elliot Health System (EHS) is the largest provider of comprehensive healthcare services in southern New Hampshire. It is a full service community resource made up of doctors' offices, primary and specialty care providers, inpatient and outpatient care, access to services 24 hours a day through Elliot ON-CALL, rehabilitation services, state-of-the-art neonatal, maternity, and pediatric care, community services and education, wellness programs, and many other services. The health system also provides services such as access to primary care physicians through the Elliot Physician Network, integrative or alternative medicine therapy, home health care through the Visiting Nurse Association of Manchester and Southern New Hampshire, Inc., assisted living facilities through Pearl Manor, Adult Day Programs, and one-day surgery services, among others.</p>  |
| <i>Requirements</i> | <p>The Director of Planning will report to the Senior Vice President of Government Relations, Public Policy, Community Health &amp; Strategic Planning. This individual will provide leadership, direction, and management of business development and strategic and operational planning services for the Elliot Health System. This individual is responsible for identifying, developing, and implementing business development strategies. He or she will work with senior management and department directors to identify organizational strengths, weakness, and business opportunities. This individual will investigate system diversification into new businesses, identify and coordinating strategic alliances and/or partnerships, and oversee organization development projects.</p> <p>The ideal candidate for this position will possess a master's degree in business administration or health care administration, along with seven to ten years of healthcare planning and business development experience, with a specific involvement in long-range strategy development. Prior experience in comprehensive business plan development is required, and coordination and support of multi-institutional planning activities is desirable.</p> |
| <i>Contact</i>      | <p>If you are interested in the position, would like to refer a colleague, or would like more information, please feel free to contact:</p> <p>Sharman McGurn at (312) 876-9800 or via e-mail at <a href="mailto:smcgurn@qlksearch.com">smcgurn@qlksearch.com</a></p>  |