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President's Message
Closing Thoughts
by John Steen

In this, my final President's Message, I'd like to share a variety of thoughts on health policy with you. Such thoughts always accumulate in my mind faster than I can translate them into coherent commentaries. So here goes.

As a philosopher, my own choice of health policy as a new career direction in the 1970s was recently explained to me simply and convincingly by another philosopher, James Lindemann Nelson, when he wrote:

"Robert Oppenheimer, it is reported, once said that he was attracted to physics because, in the early 20th century, physics was the best way to do philosophy. I suspect that one of the considerations that got a good many philosophers engaged with biomedicine in the late 20th century was a similar feeling: reflecting on developments in health care provided the best way – or at least, a very good way – of doing philosophy."¹



The Code of Ethics developed by the American Public Health Association² states:

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Closing Thoughts

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- “Public health should achieve community health in a way that respects the rights of individuals in the community.”
- “Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.”

This is respectful of individual autonomy in populations considered in the aggregate, and it avoids excesses of paternalism in public health interventions.

However, few who work in public health realize how many of its practices violate the Kantian moral principle to “act so as to treat humanity, whether in your own person or that of another, always as an end and never as a means only.” The key is never to lose sight of the full implications of the aim to treat *humanity*. So many otherwise worthwhile initiatives, for which social marketing furnishes many good examples, are of instrumental effectiveness, but neglectful of the

autonomy of the individual persons involved. And the predominance of the instrumental approach to social problems reflects the bias in favor of measuring the efficacy of interventions in behavioral terms rather than in normative terms that consider the intention of people to achieve well being by living a good life.

To incorporate the full moral significance of this into the practice of public health “would involve toleration of high levels of uncertainty in trying to aid people to improve their own skills of practical autonomy, rather than categorizing them in terms of preconceived theories with resulting automatic formulas for treatment.”³ David R. Buchanan’s book *An Ethic for Health Promotion: Rethinking the Sources of Human Well-Being*⁴ is admirably clear in arguing these points. About health promotion, he writes, “whenever we treat people as if we know what they need better than they do themselves and whenever we assume that their behavior is caused or conditioned by antecedent factors (which tacitly sanctions the right to intervene, since they are evidently not fully responsible for the choices they make), we treat them as a means to serve our ends.”

Our ends aren’t necessarily theirs. If we truly wish to promote their health, we must promote their ability to think for themselves and exercise their own judgment. Our intent must be their empowerment and not their manipulation.



Now that the prospect of developing a national health care system that is universal in scope has become one of the defining issues for domestic politics, we should see it as the opportunity to create one more advanced than any other in embodying the best thinking on human rights. There is no better representation of that thinking than the Universal Declaration of Human Rights⁵, so let that be the platform. It goes well beyond health care, as health promotion must, for “the goal is to improve not only health status but human development, which embraces equity, solidarity, social justice, human rights, and moral and ethical imperatives.”⁶

In 1946, the delegates to the UN Commission on Human Rights elected Eleanor Roosevelt their Chairperson, and that marked the zenith in international respect for the role the U. S. was playing in the world. The world needs us to play that role again. And our nation needs to be re-inspired with the faith that by working together we can at the same time improve our own lives and the rest of the world. To think we can do that, to want to do that, is the essence of the *liberal* mind. Both goals require us to embrace once again

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Coordinated Health Planning for Rhode Island in the 21st Century

By Terrie Wetle, Stephanie Kissam, and William J. Waters, Jr.

What are the priorities for health planning in the 21st century, and does the State of Rhode Island currently have the capacity to do coordinated health planning? In the Coordinated Health Planning Act of 2006 (RIGL 23-81), the Rhode Island General Assembly tasked the Department of Health (DOH) to convene a multi-stakeholder advisory committee to provide recommendations to the legislature addressing whether DOH has the capacity and the authority to engage in coordinated health planning, and additionally to develop a “plan for health planning” in Rhode Island.

Several local health care reform advocacy organizations were involved in developing this legislation in 2006. The revival of interest in health planning reflects a frustration with the proliferation of specialty health care services and facilities since the State of Rhode Island discontinued the development of State Health Plans. (The most recent was 1992.) Rhode Island’s Certificate of Need program and other regulatory activities related to health system development have operated largely with the aid of studies dedicated to applications received, instead of in the larger context of prospective planning.

As we reported in the article “State Health Planning Survey” in the first quarter 2007 issue of this newsletter, Rhode Island is not unusual in its limited health planning activities. A minority of states report having a “Health/Medical Plan” (different from a State Health Plan, which would also include population-based health improvement such as Healthy People 2010). Perhaps more tellingly, the article notes that none of the respondents to the survey reported that health services planning had a high impact on health cost trends.

Without a clear model for health planning from other states, or a recent history of successful health planning locally, what would an effective health planning process look like for Rhode Island? Participants on the Coordinated Health Planning Advisory Committee convened by DOH in response to the 2006 legislation met monthly between October 2006 and March 2007 to consider this question. The Committee, chaired by Terrie Wetle, Associate Dean of Medicine for Public Health at Brown University, included consumers and consumer advocates, the CEOs of Rhode Island’s major health insurers, the CEO of a community hospital,

and representatives of the several primary care associations, long-term care providers, and state agencies.

The Advisory Committee made the following findings:

- The health care system has not and will not transform optimally or effectively without a robust health planning process that features collaboration and coordination across all public and private sector participants.
- The state does have the authority to establish a health planning process; however, additional authority is recommended to implement the health planning process as envisioned in the report.
- The state does not have sufficient capacity to establish this health planning process. Existing capacity is limited to conducting isolated health planning studies that are single-issue and uncoordinated with a comprehensive plan.

The Advisory Committee and the Director of Health made the recommendations listed in the box on the next page in a report to the General Assembly on April 1, 2007.¹

The Advisory Committee noted repeatedly that Rhode Island’s health care system must transition from one based on competition to one that is rewarded for collaboration and coordination. A coordinated health planning process that values both public and private input is the first step.

The Director of DOH and the Advisory Committee worked hard to recommend a health planning process that would be used by multiple parties in the state and would be revisited often. Thus, the recommendations in their report favor infrastructure, governance, and public accountability mechanisms designed to provide traction for health planning reports in health care policy-making, instead of leaving health plans to gather dust on a shelf.

The development of this advisory “plan for planning” report and its recommendations garnered a high level of community interest and participation. Importantly, it demonstrated that a public-private collaboration can

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Coordinated Health Planning for Rhode Island

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reach consensus among a broad array of stakeholders and set forth goals and direction for Rhode Island's health care system.

Indeed, in the 2007 legislative session, the General Assembly passed Coordinated Health Planning bills² that reflected the recommendations of the Director of DOH and the Advisory Committee. Rhode Island's Governor vetoed the bills, noting that the creation of a new Council with over 20 members from different sectors and the responsibility to meet at least every 60 days "added another layer of bureaucracy" and "duplicates functions already being performed by Executive branch agencies." Instead, the Governor committed the state to coordinated health planning through an executive order³ issued on September 24,

2007. The executive order included most of the recommendations in the Coordinated Health Planning report, but gave the State administration more flexibility to use existing advisory committees rather than to create new infrastructure. On October 30, the General Assembly overrode the Governor's veto of the Coordinated Health Planning legislation.

The revival of health planning interest in Rhode Island may portend rising interest in other states. The question remains as to whether a new strategy for health planning can meet the demand for an improved 21st century health care system.

¹The full report is available at www.health.ri.gov/chp.

²S648 Sub A and H6125 Sub A.

³Executive Order 07-08

Recommendations to Rhode Island's General Assembly

Objectives. Rhode Island's coordinated health planning process should have the following objectives:

1. Conduct ongoing assessments of the state's health care needs and health care system capacity. These assessments should be used to determine the most efficient and affordable capacity and allocation of providers, services, and equipment that will best serve the health of Rhode Islanders;
2. Review and recommend innovative models of health care delivery that should be encouraged in Rhode Island;
3. Review and recommend health care payment that rewards improved health outcomes;
4. Evaluate the impact of the health planning process through measurements of quality and appropriate use of health care services;
5. Promote the adoption of technology that improves the availability of health information across the health care system; and
6. Recommend legislation and other actions that achieve accountability and adherence in the health care community to health planning directives.

Infrastructure. An Office of Health Care Planning and Accountability should be created within DOH. New resources would be necessary in this office to coordinate data analysis, system-wide goal development, planning, and plan implementation on behalf of all Rhode Islanders – health care consumers, providers, and payers.

Governance. The Director of DOH should appoint a Health Care Planning and Accountability Council that would oversee the health planning process and be advisory to the state. Members of the Council would include consumers, providers, purchasers, and the major insurers.

Public Accountability. Rhode Island's health planning process must publicly report, on an annual basis, the current health care system status, health care system goals, and any progress or barriers to achieving those goals. This report will provide the basis for holding health care system participants accountable for developing policies that are consistent with achieving health system goals.

None So Blind As Those Who Will Not See

By John Steen

It seems obvious that we have closed minds about American health care, a condition that has been ascribed to American education as well. Twenty years ago, Allan Bloom's *The Closing of the American Mind*¹ took a radically unorthodox view of American education much as the documentary *Sicko* is now doing for health care. His philosopher's observation on an insidious political process at work in our society provides insight into the real barrier we face in policy reform, not just in health care: "The most successful tyranny is not the one that uses force to assure uniformity but the one that removes the awareness of other possibilities, that makes it seem inconceivable that other ways are viable, that removes the sense that there is an outside."

Doublethink

In my President's Message in the 3rd Quarter issue, I wrote about the bizarre views of health care held by many conservative economists, including a quote from the National Center for Policy Analysis (NCPA). On September 24, John Goodman, NCPA President, issued an e-mail "Health Alert" announcing that he was establishing "the Mondrian Award for Ineffectiveness in Health Policy." Thinking he may have been reading my President's Messages, I read on only to learn that "the award will go to the program, agency or proposal that promises the least health outcome for the most dollars spent," and that he had given it the name "Mondrian" to signify the *minimalist* nature of the health policy thus selected. Well, okay, he had my attention. I was eager to find out which among all the Republican policies he had in mind, but he hadn't yet selected one. Instead, he just wished to discuss the award's potential to identify so much waste. Then I came across this paragraph:

"Were he alive today, Lyndon Johnson would surely qualify for a Lifetime Achievement Mondrian for giving us Medicare. This program has an unfunded liability six times the size of Social Security's. Yet according to MIT economist Amy Finkelstein, it has improved the health care of the elderly not one whit."

I'll refrain from the temptation to endnote this with more about Amy Finkelstein's "thinking." If this does-

n't look to you like a distorted view of our social and political reality, nothing I could write will reveal it to you. I just wonder how much of the distortion is economic, how much is political, and how much is *moral*.



There is a moral blindness in our nation, evident in national politics ever since Ronald Reagan said in a speech in 1964: "We were told four years ago that 17 million people in America go to bed hungry every night.... Well, that was probably true. They were all on a diet." And now, due to our political blindness, the nation has been put on such a diet for the last seven years.

The current President's explanations about why he would veto the expansion of the State Children's Health Insurance Program (SCHIP) proposed by Congress led him to assert that the uninsured "... have access to health care in America. After all, you just go to an emergency room." This can have some credence only for those who have no concept of what a health care system is, nor any appreciation of the proper role of public

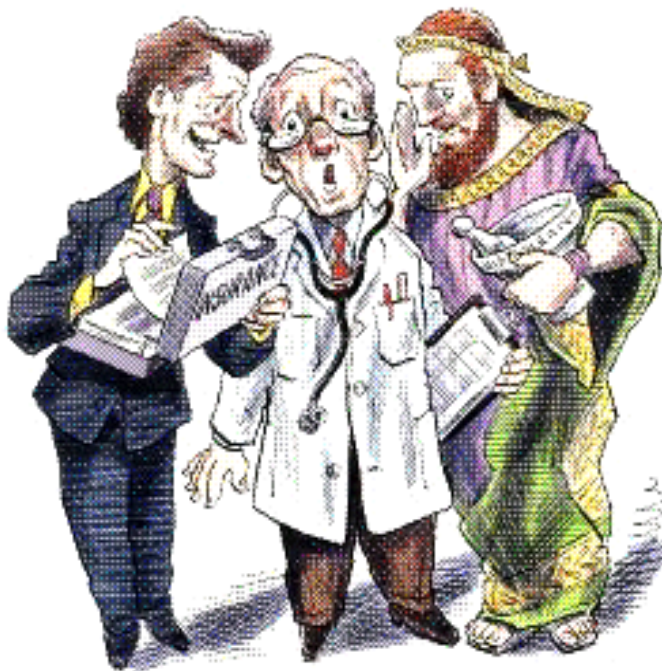
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Physician Quality Data and Measures: Update

Questions about the utility and validity of ranking physicians on the basis of insurance plans' claims data, with the expectation that it would (or should) influence consumer choices and behavior, were expressed in an article in the last issue of this newsletter.¹ Shortly thereafter, in early October, the Robert Wood Johnson Foundation announced that it would provide \$16 million in grants over 3 years for a new program that will combine Medicare and private health insurers' claims data to provide more complete and accurate information on the cost and quality of physician care.

The project aims to provide a broader picture of physicians' performance across their entire practices. It is intended and designed to support the efforts of the Quality Alliance Steering Committee (QASC)² to spur the adoption of consistent, definitive performance measures. It will use quality measures supported by the National Quality Forum.

The Brookings Institution's Engelberg Center for Health Care Reform is to receive \$8.7 million and the America's Health Insurance Plans Foundation \$4.2 million. An additional \$3 million in grants will be available to identify practical (feasible) cost containment measures and to undertake associated activities and studies.



According to project organizers, the broader, consolidated array of quality and cost information is needed to:

- Help consumers make informed decisions on which physicians they consult, although initially they will be able to compare information only on group practices;
- Enable physicians to make improvements in health care by comparing their performance with that of other doctors; and
- Guide effective policies, payment policies, and consumer incentives that reward or foster better provider performance.

Data from multiple health plans are to be collected under the strategic guidance of the QASC. Medicare data is to be contributed by the federal government. A pilot set of standard performance measures is then to be implemented by aggregating the data by physician and provider group. The results should provide a more comprehensive picture of the care provided by a given physician across his or her practice as compared to national standards.

Identification and measurement of racial and ethnic disparities in all aspects of the care provided is considered a critical aspect of the project. This focus is intended to help practitioners develop specific interventions that attempt to minimize differences.

The Agency for Healthcare Research and Quality (AHRQ) is to provide the data to communities for use by all interested parties. It will also collect data on how communities are using the data to improve care.

All aspects of the project are to be completed by 2010, according to participants.

¹“Physician “Quality” Data,” *Health Planning Today*, Fall 2007, p.4

²The formation of the QASC by two health care quality alliances, the Ambulatory Care Quality Alliance and the Hospital Quality Alliance, to “better coordinate the promotion of quality measurement, transparency, and improvement in care” was announced in July 2006. The QASC Chairman is Carolyn Clancy, AHRQ Director.



Policy Perspective

By John Steen

NJ Commission on Rationalizing Resources

After issuing its Interim Report in late June (reported in the last “Policy Perspective”), the New Jersey Commission on Rationalizing Health Care Resources held three public hearings in July and August. The gist of the testimony it heard was best summed up by the spokesperson for the New Jersey Hospital Association, who stated that “the state needs a better health planning process.”

The state eliminated its statewide health planning agencies in 1997, and largely deregulated hospitals by eliminating rate-setting in 1992. What ensued was an expensive hospital arms race, and the proliferation of unregulated ambulatory surgery centers in the suburbs that weakened the cities’ safety net hospitals. The average operating margin for the state’s hospitals fell last year to 0.6% from 1.6% in 2005. The inner city hospitals are now proponents of restoring certificate of need for specialized services, including elective percutaneous coronary intervention (PCI, or angioplasty), and they see the Johns Hopkins research project known as Atlantic C-Port-E permitting PCI for three years without cardiac surgical backup as unwise. Meanwhile, the nine suburban hospitals in the project are hoping that it will disprove the need for regulatory control through certificate of need. Between April 1, 2006 and June 30, 2007, those hospitals performed a total of 1,101 elective angioplasties with four deaths. On November 15, the Health Care Administration Board approved new regulations proposed by the state’s Department of Health and Senior Services under which those hospitals would apply for certificates of need that might be awarded next summer allowing up to 12 hospitals to perform such procedures. On November 29, the state’s Supreme Court concurred with the continuation of the demonstration program.

Furthering Planning Goals through Report Cards

On August 30, New Jersey released a comprehensive report on the volume of specialized surgical procedures and medical conditions in its hospitals.¹ The state’s Department of Health and Senior Services used 2005 hospital inpatient discharge data to compare New Jersey hospitals to national standards derived from the Inpatient Quality Indicator (IQI) module of the Agency for Health Care, Research and Quality

(AHRQ). The IQI module contains 32 indicators that reflect the in-hospital quality of inpatient care. These indicators are grouped into three major categories: volume indicators, mortality indicators and utilization indicators.



In addition to coronary artery bypass graft (CABG) and percutaneous transluminal angiography (PTCA), such lower volume surgeries as abdominal aortic aneurysm (AAA) and carotid endarterectomy, and such medical conditions as acute myocardial infarction (AMI) and congestive heart failure (CHF) are included. Overall the report finds that surgical and medical death rates in New Jersey generally are in line with or better than national averages. This report should prove useful in stimulating the state’s hospitals to engage in continuous quality improvement, and it is a worthy model for other states to emulate toward the same end.

In 1994, while I directed a regional health planning agency in the state, I produced its first report on the risk-adjusted mortality rates of its hospitals for such procedures and recommended that the state issue report cards on medical outcomes in order to promote their improvement. It has been doing so ever since, beginning with a report on CABG using 1994-95 data, released in 1997.

The issuance of such reports should be seen as health planning, and the time-honored principles for such procedures should be followed scrupulously. A study by the George Washington University School of Public Health and Health Services and the Robert Wood Johnson Foundation² was released in October examining the ethical and legal implications of publicly ranking physicians. It finds that such reporting needs to assure the openness of standards development, of the measurement process, and of the method for identifying and correcting errors. Input from those being measured has to be accommodated within the process. Transparency is the prerequisite for fairness.

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Pennsylvania Hospitals and Surgery Centers

On November 30, the Pennsylvania Health Care Cost Containment Council (PHC4) issued a financial report on specialty health facilities.³ In 2006, outpatient surgical centers reported margins of 21%, while general acute-care hospitals had a total margin of 5.5% and an operating margin of 4.2%. Medicaid was the source of only 2.95% of surgicenter net patient revenues, while it accounted for 11% of hospitals' patient revenue. Over the last ten years, in the absence of a CON program, the number of outpatient surgical centers has grown from 48 to 232⁴, and last year 27.5% of all diagnostic and surgical procedures performed in outpatient settings were performed in such facilities.

Psychiatric hospitals reported operating margins of 5.31% for 2006, with for-profits reporting 9.6% and nonprofits 0.07%.

Nurse Staffing Ratios

A new systematic review of the link between an acute care hospital's registered nurse-to-patient ratio and the health outcome of the patients under their care⁵ finds that RNs are key to patient safety. Researchers evaluated 28 studies in which RN staffing per shift averaged about three patients per RN in ICUs, four patients per RN on surgical units, and four patients per RN for medical patients. Their results showed that by increasing the number of RNs on staff by one full-time equivalent per patient day, there were 9% fewer hospital-related deaths in ICUs, 16% fewer in surgical patients, and 6% fewer in medical patients. This would amount to five fewer deaths in ICUs, five fewer among medical patients, and six fewer among surgical patients per thousand hospitalized patients. Length of stay was reduced by 31% in surgical units and 24% in ICUs where there was a reduction in adverse patient events such as hospital acquired pneumonia (by 30%), respiratory failure (by 60%), and cardiac arrest (by 28%).

Long Term Care: A Better Nursing Home

There is now a firm basis for the further development of "Green Houses" in preference to the traditional, more institutional, nursing home. Green Houses are self-contained residential dwellings of just seven to ten residents requiring nursing home levels of care.

A study of these smaller-scale housing models⁶ compared health outcomes and quality of life for Green House residents in four ten-person facilities with residents at two traditional nursing homes. It found that Green House residents experience better quality of life, with the same or better quality of care, than those in the comparison homes.

The researchers used data on 11 measures pertaining to quality of life: physical comfort, privacy, dignity, autonomy, ability to enjoy food, spiritual well-being, security, individuality, functional competence, relationships, and ability to engage in meaningful activities. Green House residents scored better on seven of those measures, and equivalent to the traditional nursing homes on the remaining four. Quality of care was measured using indicators derived from Minimum Data Set assessments. It was found that Green House residents experienced lower rates of depression, bed rest, reduced activity, and decline in functional abilities, but did have higher rates of incontinence than did residents in one of the comparison settings.

For-profit Hospitals

A study in the October 9 issue of the *Journal of the American College of Cardiology*⁷ reports on the question of whether for-profit status influenced hospitals' patient case mix, care, or outcomes among patients with acute myocardial infarction. The study reviewed data on 145,357 patients in 532 hospitals over a five-year period (2001-2005), and it adjusted for clinical and facility factors using regression modeling. The authors' concluded: "We found no evidence that for-profit hospitals selectively treat less sick patients, provide less evidence-based care, limit in-hospital stays, or have patients with worse acute outcomes than non-profit centers."

Access Denominated in Economic Theory

To anyone but a conservative economist, seeing the acquisition and use of health insurance to meet health care needs as a "moral hazard" is surely a jaundiced view of human society. Its currency among these economists is based on a few studies that purported to show health insurance to represent a net welfare loss for society, leading to their support for cost sharing features designed to discourage such use by restricting access to care. The theoretical foundation for this way of thinking goes back to Mark Pauly, Wharton School economist in 1968, but the empirical basis is the

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RAND Health Insurance Experiment (1983). Today's theories of the efficacy of "consumer-driven health care" are based on them.

John A. Nyman has been critical of these interpretations and in a new article he argues for seeing the previous studies as supporting health insurance as a welfare gain for society that is to be encouraged. He concludes that "there is probably no other investment that we can make as a society that would generate as great a net return on welfare as finding a politically acceptable mechanism for insuring the large portion of U.S. citizens who are currently uninsured."⁸



¹Inpatient Quality Indicators, New Jersey 2005, New Jersey Department of Health and Senior Services, Office of Health Care Quality Assessment, July 2007. Available at: <http://www.state.nj.us/health/healthcarequality/documents/iqi2005.pdf>

²<http://www.rwjf.org/files/research/physiciantiering102007.pdf>.

³<http://www.phc4.org/reports/fin/06/default.htm>.

⁴According to the American Association of Ambulatory Surgery Center, hospitals have an ownership interest in 20% of the nation's nearly 5,000 surgery centers but own only 3 percent outright.

⁵Robert L. Kane et al., "The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis." *Medical Care* 45 (12): 1195-1204 (December, 2007). <http://www.lww-medicalcare.com/pt/re/medicare/abstract.00005650-200712000-00011.htm>.

⁶R. A. Kane, T. Y. Lum, L. J. Cutler et al., "Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program." *Journal of the American Geriatrics Society*, June 2007 55 (6): 832-839. <http://www.blackwell-synergy.com/doi/abs/10.1111/j.1532-5415.2007.01169.x>.

⁷Bimal R. Shah et al, "The Impact of For-Profit Hospital Status on the Care and Outcomes of Patients With Non-ST-Segment Elevation Myocardial Infarction." *Journal of the American College of Cardiology*, 2007; 50: 1462-1468. <http://content.onlinejacc.org/cgi/content/abstract/50/15/1462>.

⁸John A. Nyman, "American Health Policy: Cracks in the Foundation." *Journal of Health Politics, Policy and Law*, Vol. 32, No. 5, October 2007, 759-784; quotation, p.782. <http://jhppl.dukejournals.org/cgi/reprint/32/5/759>

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health and prevention in that system. If they did, they would see the need to use emergency rooms for any but true emergencies as failures that ought to be obviated by a health care system that places public health on top and values personal medicine for providing a medical home for health education and preventive care. And it is the lack of such care leading to the misuse of ERs that causes people to descend into bankruptcy and poverty. Here we see the promulgation of the same distortion "that removes the awareness of other possibilities," and through it, "removes the sense that there is an outside," in the fateful words of Allan Bloom. I hope the time has come for us to see what lies outside such a treasonable lack of governance.

And we should see that even for those of us with private insurance, effective, appropriate care is often outside of our reach due to the corruption of such "insurance" into something hardly worth having. Might we decide to do something about uninsurance when we realize that we're all uninsured? Above all by a lack of good government, for, in the words of Dr. Gro Harlem Brundtland, former Director-General of the WHO, "the careful and responsible management of the well-being of the population – stewardship – is the very essence of government." And in the words of Franklin Delano Roosevelt, speaking to the New York State Legislature in 1931:

"The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health. The state's paramount concern should be the health of its people."

The Price of Everything; the Value of Nothing

"Finally, there came a time when everything that men had considered inalienable became an object of exchange, of traffic, and could be alienated. This is the time when the very things which till then had been communicated, but never exchanged; given, but never sold; acquired, but never bought – virtue, love, conviction, knowledge, conscience, etc. – when everything, in short, passed into commerce. It is the time of general corruption, of universal venality, or, to speak in terms of political economy, the time when

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the virtue of *governing*, seeing that our government is what we have created in order to do that.

It is recognition of blind spots like our views on poverty that is leading to reformulations of some of our basic social policies.⁷ Insights gained largely from the U.K. and other European countries about the damage to people due to their *exclusion* from social processes have inspired The New America Foundation to name *social inclusion* as a social policy that can integrate a host of interconnected societal goals for well-being.

“Social inclusion is based on the belief that we all fare better when no one is left to fall too far behind and the economy works for everyone. Social inclusion simultaneously incorporates multiple dimensions of well-being. It is achieved when all have the opportunity and resources necessary to participate fully in economic, social, and cultural activities which are considered the societal norm.”⁸

The Foundation’s working paper continues:

“The concept of social inclusion goes well beyond our limited poverty definition in its ability to communicate a full range of means for social policy to boost income and build human capital. Social inclusion approaches provide an inequality-based understanding of income and well-being, and build understanding of social issues by naming a phenomenon that isn’t adequately identified in the United States by existing terms.”

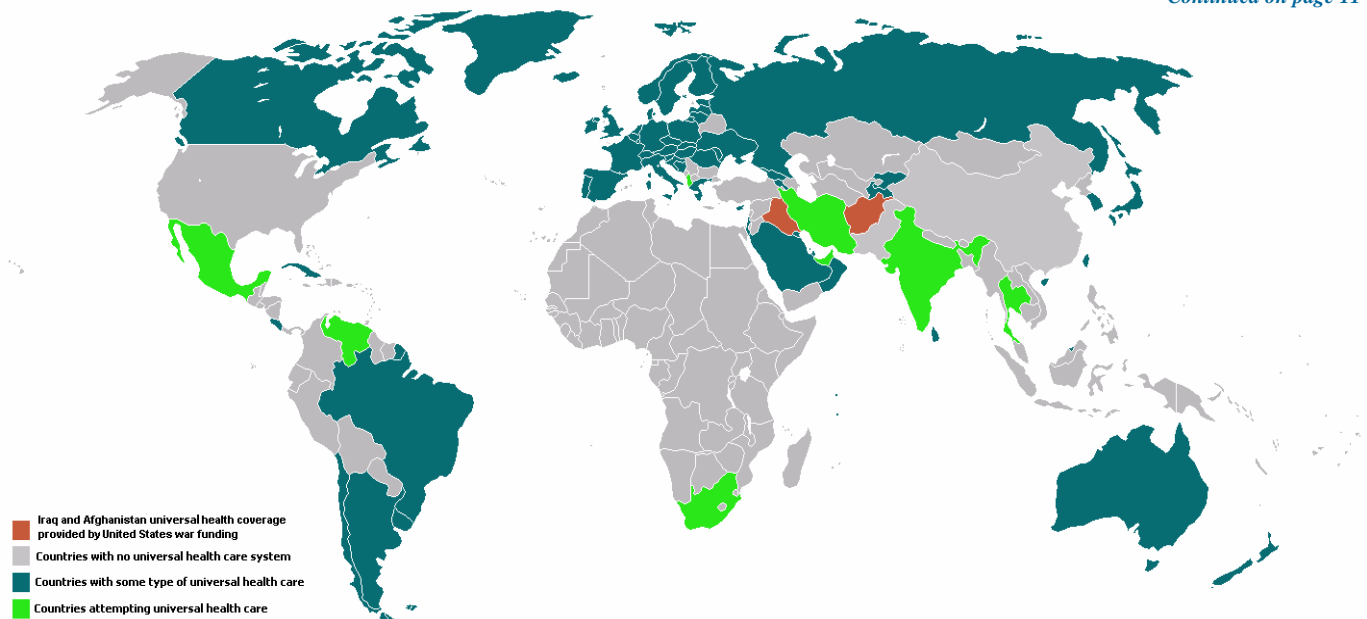
The effort here is toward the redistribution of societal resources to achieve fairness, the idea of political liberalism in a society in which freedom is a priority exemplified by John Rawls in *A Theory of Justice*.⁹ A report by the Center for Economic and Policy Research¹⁰ found that the United States fares worse than Europe on a range of social and economic indicators for reducing social exclusion, including most measures of poverty, education, health, and crime. It reported that the U.S. reputation for economic and social mobility is a myth, noting that low-income American workers have less chance of improving their incomes than do those of any other OECD country.

In a report entitled “Understanding Mobility in America,”¹¹ the Center for American Progress stated that

“By international standards, the United States has an unusually low level of intergenerational mobility: our parents’ income is highly predictive of our incomes as adults. Intergenerational mobility in the United States is lower than in France, Germany, Sweden, Canada, Finland, Norway and Denmark. Among high-income countries for which comparable estimates are available, only the United Kingdom had a lower rate of mobility than the United States.”

While we wish to reduce individual disparities, European nations foster social cohesion and solidarity. Both approaches are necessary to achieve social justice. We seem to have lost our sense of striving toward common purposes. What we see as redressing the growing imbalances in our society we once saw as investing in the common good.

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The thought that I now find most comforting is that history is cyclical, an idea that goes back at least to Plato in the *Timaeus*, and one that has always fascinated historians.

“At periodic moments in our history, our country has paused on the threshold of a new epoch in our national life, unable for a moment to open the door, but aware that it must advance if it is to preserve its national vitality and identity. One feels that we are approaching such a moment now – that the mood which has dominated the nation for a decade is beginning to seem thin and irrelevant; that it no longer interprets our desires and needs as a people; that new forces, new energies, new values are straining for expression and for release”.

— Arthur M. Schlesinger Jr.¹²

Old values, original to our republic, might now be revived too. I fervently hope that one day soon we can reaffirm the vision of our founding fathers, the same vision that two centuries later gave the world the Universal Declaration of Human Rights. In a supreme show of hypocrisy, our President addressed the UN General Assembly in September, making the Declaration and its Article 25 the keynote of his speech¹³ and quoting it in part: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food and clothing and housing and medical care.” And then, less than two weeks later, the President vetoed the expansion of SCHIP, one of the few “safety net” programs able to redress in part the human rights violation represented by our barriers to health care.¹⁴

“To announce that there must be no criticism of the President, or that we are to stand by the President right or wrong, is not only unpatriotic and servile, it is morally treasonable to the American public.”

— Theodore Roosevelt¹⁵

If there’s been a theme common to my commentaries, it’s our need to revive and rethink who we are as Americans. Next year is a propitious time to do that, so I’m going to leave the last word to Edward Abbey who said: “Society is like a stew. If you don’t keep it stirred up, you get a lot of scum on top.”¹⁶

¹“Moral Teachings from Unexpected Quarters: Lessons for Bioethics from the Social Sciences and Managed Care,” *Hastings Center Report* 30, no. 1 (2000): 12-17. Oppenheimer had studied oriental philosophy in college.

²*Principles of the Ethical Practice of Public Health*. Public Health Leadership Society, 2002, p.7. Available at: <http://www.apha.org/NR/rdonlyres/1CED3CEA-287E-4185-9CBD-BD405FC60856/0/ethicsbrochure.pdf>.

³Robert Bellah, “Social Science as Practical Reason,” in D. Callahan and B. Jennings, eds., *Ethics, the Social Sciences, and Policy Analysis*, Plenum Press, 1983, p.43.

⁴Oxford University Press, 2000. Quotation from p.19. See also his “Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health,” *American Journal of Public Health* 98:1 (January 2008). <http://www.ajph.org/cgi/content/abstract/AJPH.2007.110361v1>.

⁵Adopted on December 10, 1948. Available at: <http://www.un.org/Overview/rights.html>. Human rights ideals have yet to be institutionalized in those nations that have adopted them in principle. For a good overview of the role that human rights and social justice should be playing in fostering a better society, see *Human rights, a tool for change*, an educational booklet produced by the voluntary sector in England, available at http://www.esrcsocietytoday.ac.uk/ESRCInfoCentre/Images/9339_ESRC_human_rights_tcm6-24471.pdf.

⁶Rosalia Rodriguez-Garcia and Mohammed N. Akhter, “Human Rights: The Foundation of Public Health Practice,” *American Journal of Public Health* 90:5 (May 2000), p.694. <http://www.ajph.org/cgi/reprint/90/5/693>.

⁷The best introductory text for the new reassessment of social welfare in the U.S. is: Christopher Howard, *The Welfare State Nobody Knows: Debunking Myths about U.S. Social Policy* (Princeton University Press, 2006)

⁸Heather Boushey et al, *Social Inclusion for the United States*, April 2007, p.2. For the second quote, see p.5. <http://inclusionist.org/files/socialinclusionusa.pdf>.

⁹Harvard University Press, 1971.

¹⁰John Schmitt and Ben Zipperer, *Is the U.S. a Good Model for Reducing Social Exclusion in Europe?* Center for Economic and Policy Research (July, 2006). http://www.cepr.net/documents/social_exclusion_2006_08.pdf.

¹¹April 26, 2006; p.i. http://www.americanprogress.org/issues/2006/04/Hertz_MobilityAnalysis.pdf.

¹²“The New Mood in Politics” (1960), in *The Politics of Hope*, Riverside Press, 1962.

¹³<http://www.whitehouse.gov/news/releases/2007/09/20070925-4.html>.

¹⁴The Institute of Medicine found that we suffer 18,000 unnecessary deaths each year through lack of health insurance (2004): <http://www.iom.edu/?id=19175>.

¹⁵In *The Kansas City Star*, May 7, 1918. Roosevelt was in disagreement with President Woodrow Wilson’s views on World War I.

¹⁶*A Voice Crying in the Wilderness: Notes from a Secret Journal*, St. Martin’s Press, 1991. ♦

*None So Blind as Those Who Will Not See**Continued from page 9*

everything, moral or physical, having become a marketable value, is brought to the market to be assessed at its truest value.”

— Karl Marx²

What I think to be the most egregious blind spot shared by conservative economists is their failure to see caregivers' ethos of devotion to their patients as **priceless**. As I wrote in my previous President's Message, it is “ironic then for us to see profit-driven, high-cost medicine as the price we pay for incentivizing physicians to perform well, instead of as a measure of the depreciation of professional life, the corruption of medicine.” In a recent op-ed column in *The New York Times*, Barry Schwartz, professor of psychology at Swarthmore College and author of *The Costs of Living: How Market Freedom Erodes the Best Things in Life*³, writes about the stupidity of incentivizing ballplayers and school teachers. Not only are bonuses insulting to teachers, he notes that “beyond the insult, such an incentive scheme is an effort to fix a structural problem on the cheap.” He concludes that “the more society embraces the idea that nobody will do anything right unless it pays, the more true it will become that nobody does anything right unless it pays. And this is no way to run a ballclub, a school system, or a country.”⁴ In his book, he wrote that the “continued spread of economic objectives and tactics into domains of life that people have traditionally regarded as governed by other goals and rules are turning social life into a jungle,” labeling this “economic imperialism.”

A cable television system is a good example of that jungle – a thousand available channels with few having programs worth watching, and we no longer know how to find those few. By making economic wealth the sole value for society, the currency of life is devalued for everyone.

The almost total ascendancy of libertarian values over communitarian ones – too much freedom – exacts a serious moral, social, and emotional price. The orthodoxy of neoclassical economic theory elevated to a sort of secular religion has managed to redefine “the cost of living” in terms of the alienation of those who follow it, alienation from our authentic self and from our obligations to each other. We manage to think we love our individualism without realizing how misguided our ways of expressing it have become. All these blind spots should be seen for what they are, symptoms of how we have come to live our everyday lives without a

sense of the values implicit in living a mindful life *intentionally*. We no longer seem to see that the meaning of life consists of giving life meaning.

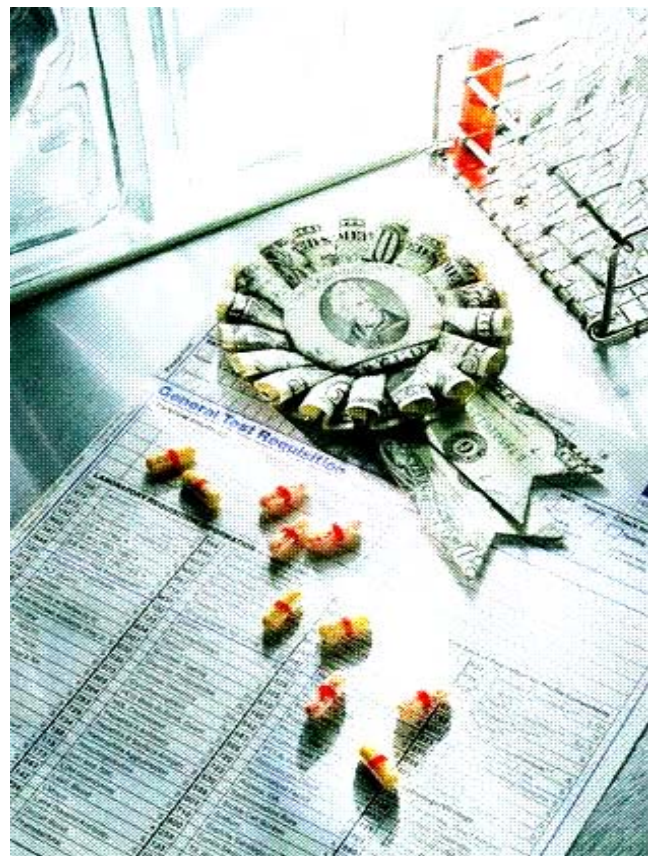
And so, Bloom's insight is that the most successful tyranny is the blindness that results in our living out the sort of impoverished lives that match the conception of human nature contained in orthodox neoclassical economics. Health care is just one of the important social institutions needing to be reformed. The success of that will be determined by how well we are able to see through the smokescreen of societal myths far upstream from it. We must see that there is an outside and redeem our original values in that clearer light that restores a truer vision of the good life.

¹Simon & Schuster, 1987. For quote, see p.249.

²*The Poverty of Philosophy*, 1847, p.33.

³W.W. Norton & Co., 1994.

⁴“Bonus Babies,” October 24, 2007. <http://nytimes.com/2007/10/24/opinion/24schwartz.html>.



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