The President’s Column
by Robert R. Vogel

In the last issue, Health Planning TODAY reported AHPA’s Membership Survey findings in an article by Sonya Albury. Using these findings, the Board of Directors challenged its standing committees to establish priorities and recommend implementation actions. The Board received those reports in February and endorsed several priority actions.

The Membership and Finance Committees focused on membership growth as a key strategy to strengthen both our organizational base and our financial stability and resources. These committees will be developing a membership value program that will emphasize AHPA’s purpose and objectives and offer attractive membership benefits. In a related strategy, the Organizational Development Committee will research and qualify opportunities for AHPA to participate in project and grant offerings requiring a strong community health planning focus and the application of related professional skills.

The Membership and Organizational Development Committees will develop opportunities to enhance AHPA’s value and visibility. Priorities include enhancing AHPA’s web site, expanding opportunities for communication with members, and attracting more participants to the list server with relevant and timely topics and exchange of ideas.

The Organizational Development Committee accepted additional challenges as well.

Continued on page 2

Inside this Issue . . .

- The President’s Column
- Bill Would Alter Hospital Board Review Powers
- Healthcare Reform: A Planner’s Standards
- HCFA Releases Outpatient PPS Regs!
- Data Warehousing for Public Health, Part II
- Health: The Stealth Issue
- Sourcebook, 1999 Edition
- Come See Us on the WEB!
A plan to drastically change the way the state regulates hospital construction in Illinois could hurt communities and potential patients, consumer advocates say.

But hospitals say they simply want the Illinois General Assembly to update a 26-year-old process so it makes sense in the new health care environment—one where consumers can count on market forces just as well as regulation.

“We’re not asking here for a revolution,” said Howard Peters, a lobbyist for the Naperville-based Illinois Hospital & Health Systems Association. “We’re asking for incremental improvement in the process.”

The proposal, Senate Bill 807, would reduce the number of capital projects that would have to be evaluated by the Springfield-based Illinois Health Facilities Planning Board.

The bill passed the Republican-controlled Illinois Senate overwhelmingly last month, but changes in the powers of the Illinois Health Facilities Planning Board still must win the support of the Democratic-run House.

A House committee approved the plan, with minor changes.

“This is clearly a very anti-consumer bill,” Jim Duffett, executive director of the Champaign-based Campaign for Better Health Care, told the committee. “The real agenda and central component of S.B. 807 is to give the powerful hospital corporation total control of our health-care system.”

Peters responded, “That’s not the goal here at all.”

Sponsored by state Sen. Doris Karpiel, R-Carroll Stream and state Rep. Michael Smith, D-Canton, the bill’s main provisions would exempt certain construction projects and medical equipment purchases from the state board’s review.

Medical equipment projects of $1.3 million or more now must be reviewed. The same goes for all other types of construction expected to cost $82.7 million or more.

Under the proposal, medical-equipment-related capital spending would have to reach $7 million or more to warrant review, and non-clinical capital spending—for things such as parking lots, air conditioning, carpeting and general remodeling—would be exempt.

“This is a step forward in reforming the system,” said Smith. “The planning board is kind of a self-perpetuating bureaucracy. This is an issue of whether we trust local hospital boards.” Health-care planning boards in Illinois and nationwide sprang up in response to federal law in the early 1970s. Since then, however, 18 states—including California, Indiana, Ohio and Wisconsin—have eliminated their review processes altogether.

And since the 1970s, hospital say, managed care and restricted payments by Medicaid and Medicare have done a better job than regulation in preventing unnecessary capital spending.

The planning board in Illinois has 15 voting members appointed by the governor and confirmed by the Senate. Board members don’t receive a salary but are reimbursed for expenses associated with attending meetings. Fees paid by applicants support the salaries of staff analysts and other costs.

The board is designed to prevent unnecessary duplication of services in the medical industry and protect consumers in the long run. But hospitals say the process as it now stands is too subjective, costly and time-consuming.

Cont’d. on page 8
Healthcare Reform: A Planner’s Standards
by John Steen, Director
Community Health Planning, Columbus (Ohio) Health Department

As health planners, we know our communities are not receiving the full benefit of our society’s health care resources. There is a great need for more planning to meet the needs of underserved populations, but it is policy that determines the role planning will play in the design of systems and in the allocation of resources within systems.

With this in mind, AHPA established a Public Policy Committee three years ago, and began adopting a series of policy statements which advance the values, and address the concerns, of community health planners and state regulators.

Last year, we adopted a policy statement which begins with this declaration:

“The mission of health planning is the development of comprehensive, community-oriented health systems designed to assure universal access to necessary care of the highest quality and most reasonable cost possible.”

We followed this up by adopting a series of statements about quality, community participation, and collaborative planning, three of our core values.

Our fourth core value is access, and it calls for more than just a defining statement. An adequate statement on access should answer the questions: access to what, and how. It should cover access to a range of health resources, including health information, disease prevention, health promotion, and health policy, not just to health care. And access to these resources should be seen as a right. Needing and receiving access to these resources, both as individuals and as members of communities, should be an empowering experience, never a demeaning one.

With values like these in mind, the AHPA Board has asked me to draft the following set of model standards which we might apply as criteria for evaluating the various plans and measures for “health care reform” advanced by legislators and professional, trade, and special interest groups:

MODEL STANDARDS TOWARD HEALTHCARE REFORM

1. Universal Access
   a. Insurance or entitlement
   b. Affirmative access
   c. Dignity for all

2. Primary Care and Prevention

3. Comprehensive Services With Quality Assurance

4. Consumer Choice of Providers and Procedures

5. Equitable Financing
   a. Community-rated premiums
   b. By ability to pay

Cont’d on page 4
6. **Priority for Public Health - Community Health Status Outcomes**

7. **Public Reporting and Evaluation**

8. **Consumer Participation in Planning, Resource Allocation, and Evaluation**
   a. Long-range health system goals;
   b. Local and regional priorities/population-based planning;
   c. Community health improvement and empowerment;
   d. Certificate of Need; and
   e. Accountability to consumers.

**COMMENTARY:**

By universal access, we mean access for all United States residents regardless of age, health status, employment status, or income. With either a private or a public system, access can be provided by either insurance or entitlement. Access must be affirmed by ensuring that no barriers, such as the availability of competent personnel, language, and cultural congruence, exist. All served must have their dignity respected.

Our emphasis on primary care and prevention implies a major role in providing health education to enable people to become promoters of their own wellness. All health care services should be accessible as needed, with mental health services being available as comprehensively as physical health services. Planning should be employed to minimize both over-utilization and under-utilization, and to monitor the adequacy of access through the actual use of services. For our statement on Accountability for Quality, see the AHPA web site at [www.ahpanet.org](http://www.ahpanet.org).

Consumers must have the right to choose their own health care providers and to participate in decisions about their care out of respect for them and their ability to exercise informed judgment in their own interest.

Looking at the total system, it should be obvious that there are major social justice issues to be overcome. Equitable financing in a private system requires spreading of risk through community rated premiums which acknowledge our interdependence and reduce our differences. The resources taken out of the community to fund health care should be returned as benefits to the community.

The premiums, deductibles, and co-payments, if any, should be scaled by everyone’s ability to pay, both to avoid barriers and as a matter of social justice. Our current system of financing primarily through employment-based premiums is extremely regressive in offering the greatest tax benefits, i.e., subsidies, to those with the highest incomes. Where our current system uses experience rating, it imposes monumental barriers to access for the least fortunate.

In making public health a fundamental national priority, we are acknowledging its practice of prevention on a community scale and its effectiveness. Twenty-five of the thirty years added to our life expectancy over the past century were added through improvements in public health.

There should be no surprise that, since we stand for empowering communities through planning, we seek the collection of relevant data to support that planning through public reporting processes in which consumers, as well as providers participate in evaluating outcomes. In the interests of accountability, consumers should be represented on all boards overseeing health care.

We encourage our members and other constituent readers to critique this draft of Model Standards. Your comments will assist our Board in its discussions prior to adopting and applying these standards.

How well do they accord with your values and serve your needs and those of your community? My e-mail address is <jsteen@cmhhealth.org>.

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**HCFA Releases Outpatient PPS Regs!**

The Health Care Financing Administration has issued its long-awaited regulation for an outpatient prospective payment system.

The document went on display in Washington and HCFA plans to also post the regulation on its web site at [http://www.hcfa.gov](http://www.hcfa.gov). Publication in the Federal Register was expected to occur on April 7.
Data Warehousing for Public Health, Part II
Richard K. Thomas, Ph.D.
Medical Services Research Group

As part of an NIH-funded project for the development of a public health data management system, the author has reviewed efforts by state and local health departments to integrate public health data, manage it, and distribute it.

Part I of this two-part report, which appeared in our last newsletter, summarized the status of public health data integration efforts and the prospects for true data warehouse development.

Part II below will explain ideas on how this can be accomplished.

One solution being pursued by many state health departments involves the development of a Web-enabled data warehouse. The intent is to create a framework for interfacing various categories of public health data (often with external data) and develop a mechanism for disseminating this newly integrated data to a variety of constituencies. This approach is not only being pursued by many state health departments, but by some local health departments and regional planning councils as well.

How far have public health agencies gone toward Web-based data warehousing? At this point in time, every state has some public health data available via the Internet. This Web display may be as simple as a few statistics or as complex as an interactive application for creating custom tables and generating maps. In the final analysis, however, no two states are alike in terms of their approach to data integration and Internet distribution, and these differences exist along a number of dimensions.

Some of the major areas in which differences exist among Web-based public health data management systems relate to data content, system functionality, and intended usage. While one would assume that there is a core set of public health data that would be inherent in any such system, this is not the case in reality. While it is true that many sites post data related to vital statistics, immunizations, reportable diseases and other "standard" health department activities, these are by no means universal. Some jurisdictions, for example, allow members of the general public to view their birth certificates online, while other states have laws specifically prohibiting even the display of summary data on births and deaths. Some sites include data from two or three data sets, while others may incorporate data from dozens of data sets. At the same time, the form these data take varies widely, from summary statistics to data tables to, in some cases, the actual raw data sets. The considerations that have appeared to guide the inclusion of data nationwide are the availability/unavailability of data, legal reporting requirements or prohibitions, and the demands of various constituent groups.

A second difference relates to the functionality incorporated into the Web-enabled data management system. At one extreme, there are applications that only display basic statistics in the form of "pictures". Others may simply reproduce print documents on the screen in HTML format. At the other extreme are systems that attempt to incorporate a substantial amount of functionality into their applications. These may include the ability to create custom tables choosing data from a variety of data sets; others may allow for some level of map generation. In some cases, downloading of certain information is allowed. Even in the most advanced examples, however, the extent of system functionality is limited by most standards. The ability to perform subsetting routines, drill downs, and generally "slice-and-dice" the data as desired are typically not available.

Cont'd. on page 6
A third difference relates to the purposes of the various Web-enabled applications that have been developed by state health departments and other public health authorities. On one hand, some applications have been developed almost exclusively for internal use by health departments and health researchers in the community. At the other extreme, some sites have been developed almost exclusively for use by the general public (or some segment such as policy-setters). In fact, the "mandates" that have guided the development of these sites range all across the board. Then there are those sites that appear to be designed to meet the needs of all possible constituents—from state legislators to the man in the street.

One other distinction that might be made among the various Web-based attempts to manage public health data relates to the technology platforms in use. There appears to be no two state systems that have been developed following the same design criteria and/or technological approach. Limited attention has been paid to either the database engine required to manage such a system or the programming requirements for the development of system functionality and Web enablement. A variety of different development environments have been utilized, and in many cases, non-contemporary programming approaches used. It appears that most public health agencies have utilized whatever resources were at hand and then attempted to convert the system to a Web-compatible application. Not only does this mean that every new system component presents a challenge in terms of Web enablement, but that many agencies have gone down a technological path that can only result in a dead end. The basic problem is that the design of most applications was influenced by some other factor than compatibility with the Internet.

Ultimately, the major conclusion from the extensive research is that no true "data warehouse" has yet been developed as a solution for the management of public health data. While some agencies may refer to their applications as a "data warehouse", not one of them meets the criteria that we would apply. The solution required for the management of public health data involves a Web-enabled data warehouse with the following characteristics:

**Comprehensive Data:** A true data warehouse should include all available public health data, along with data sets from other relevant government agencies and external data sources.

**Data Integration:** The data sets in a data warehouse should be fully integrated and not simply physically located on the same Web site. This means that the various categories of data should appear seamless to the user, and that it is possible to manipulate data simultaneously from disparate data sets.

**Full Interactivity:** The user should be able to control the various functions of the system, whether this involves data manipulation, report generation, map generation, and data analysis.

**Sophisticated Functionality:** The data warehouse should incorporate the full range of functionality necessary for performing a wide range of data analyses, including the ability to subset data, perform drill downs, aggregate geographies, and perform time-series analyses.

**Advanced GIS Capabilities:** Geographic information system capabilities should be an inherent component of the data warehouse, not only supporting map generation, but serving as a navigational and data management tool while providing a full range of spatial analysis capabilities.

**Analytical Capabilities:** The data warehouse should include analytical modules that allow the user to perform a wide range of analyses. These might include community assessments, community report cards, Healthy People 2010 benchmarking, behavioral risk factor tracking, and service demand analyses.

Unfortunately, there is no cookie-cutter solution that will fit every situation. The form the data warehouse takes will ultimately depend on the needs of the developer, but all warehouses should incorporate the above components. In every case, there will be unique considerations that must be addressed. And there are hard issues that must be resolved before a successful data warehouse can be implemented. Data sharing concerns must be addressed along with the issue of data confidentiality. Funding is going to be a consideration in most cases. The ability to sustain such a system for the long term after it has been developed represents another challenge.

If these challenges can be addressed, a Web-enabled data warehouse appears to be not only a good solution for the information management needs of public health agencies, but possibly the only one.
During the past two months, I have been viewing the debates of both parties’
candidates for the presidential nominations. I haven’t seen all of them, and I doubt
that I have seen any in its entirety. The views and positions on various issues
espoused by the candidates are restated over and over again before different
audiences.

My interest has been on what they say, and do not say, about health, and health care,
in the United States. Obviously, none of the candidates is against health and, from
what I can tell, they have all said that they want to protect, save, reform, improve
(choose the word or words) Medicare. They favor leaving decisions about services to
the patient and provider, but seem to ignore the fiscal implications of such choice.

Gore and Bradley not only want to keep and, perhaps, expand Medicare, they have
competing programs to extend health care access through additional government
payments for coverage of certain members of the public. The major differences
between them are over the costs of their plans and whether to continue Medicaid or
establish a substitute for it.

None of the eight address the overall health of the public. Their focus, when they
discuss health at all, is on financing health services, with the apparent assumption
that better use of existing dollars, or more dollars, will provide more health services
to individuals, or allow more individuals to gain access to services; essentially,
treatment for disease already contracted or injury already sustained.

It would be valuable for the public if the candidates gave attention to a broader view
of health, and recognized that lifting the burden of disease is a way to improve the
public’s enjoyment and quality of life. Providing health care, once illness or injury is
suffered, is but one way to address the public’s health; environmental and socio-
economic factors affect health. Preventive medicine interventions also merit attention.
Only approximately 3% of the total expenditures for health in the United States is
devoted to public health.

Consider infant mortality, widely viewed as the key indicator of the performance of
the health system of a nation. It would be interesting to know what the candidates
have thought about, and have to say about, the national infant mortality rate. It has
dropped from 12.6 per thousand births to 7.3 in the period between 1980 and 1996.
This is a substantial improvement. However, the United States ranks 25th in the
world according to the latest available data. The candidates, in their prepared
remarks and in response to questions at the debates, frequently make reference
to the greatness of the United States; that the United States is the richest, and the
most militarily powerful nation in the world, or even the greatest nation ever in
world history.

How about questions asking the candidates why the richest and most powerful nation
ranks only 25th in infant mortality, and how the candidates would address the issue?
Would any propose using part of the budget surplus to lower infant mortality at the
expense of a smaller tax cut? Our economic rival, Japan, has an infant mortality rate
of 4.26, less than 60% of our rate.

Another area certainly open for debate among the candidates is the problem of illegal
drugs in the United States, which many experts believe to be our number one health
problem because drugs are so intertwined with crime, homelessness, mental illness
and infectious diseases, including AIDS. The candidates agree that illegal drug use is
harmful to our society. There could certainly be a useful debate over approaches to
alleviate the drug problem in its various manifestations, particularly in reducing
Consumer advocates such as Duffett say they believe the hospital group’s real goal is to eliminate the agency. The bill includes a “sunset clause” that would eliminate the board in 2003 if the legislature and governor fail to reauthorize it. Peters and other hospital officials said Duffett’s claims about the hospital association’s motives are a scare tactic. The sunset clause is designed to force the state board to seriously discuss more proposals to streamline the regulatory process, Peters said.

But if the plan becomes law, it would mark the first time in Illinois that an entire state agency is targeted for elimination by a “sunset clause.” Because of that, Duffett said the plan would be the most far-reaching health care legislation to pass the General Assembly in at least a decade.

If the board were eliminated, he said, the public would have little say over health-care institution’s decisions.

House Speaker Michael Madigan, D-Chicago, hasn’t taken a stand on the bill, and neither has Republican Gov. George Ryan.

The planning board is considering making some changes on its own, such as reducing the types of projects that would need approval, said board member Richard Wright. But Wright told the House committee the proposed $7 million cutoff for board review “is way too high.” More reasonable, he said, would be $3 million or more.

He noted that the board considered $1.1 billion in capital projects in fiscal 1999 and approved almost all of the proposed spending.

On a related front, the owners of some for-profit fitness centers say the bill also would allow for more abuse of the current law by not-for-profit hospital that have build multimillion-dollar fitness centers without seeking planning board approval.

Those centers, often exempt from certain taxes, unfairly compete with the for-profits, said Mike O’Donnell, a co-owner of Riviera Country Club and Sports Center in Orland Park.

Re. Jeffrey Schoenberg, D-Evanston, the only person to vote against the plan at the House committee meeting, said the concerns of nursing homes and other health-care providers regulated by the board haven’t been considered in the debate.

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Cont’d. from page 2

Demand for drugs. What ideas do the candidates have for treating the drug problem with a health, as well as a law enforcement, strategy? Approximately 41% of those admitted to federal prisons are drug offenders, and they comprise approximately 60% of the inmates. The average yearly cost per prisoner in federal prison in 1996 was around $23,500.

How about a debate with respect to whether, if more resources were devoted not to treatment and rehabilitation programs, some of the money to be spent on the penal approach in the future might be saved by reducing the number of future offenders? The average length of stay for a federal drug offender is more than six years; only moderately successful programs could reduce the number held in prison at a cost per stay of about $150,000. Apart from the potential dollar savings, consider that the prisoner released without rehabilitation is unlikely to be productive on the “outside,” and is likely to again be housed and fed at taxpayer expense. These are the types of issues that we should be hearing discussed.

Finally, consider in the context of applying a public health approach, the recent experience with the local influenza outbreak. Occupancy in local hospitals soared, in some instances to over 90%, as influenza victims, particularly those who contracted pneumonia – a complication – sought medical help. Let’s assume, for discussion purposes, that the average hospital cost for the individuals who needed and received inpatient care for influenza was in the neighborhood of $2,500, and that most of these individuals had not received the flu vaccine.

Flu vaccine, although it is not 100% effective in preventing flu, was widely available from the Allegheny County Health Department and private sources, such as the UPMC Health System, for $10, and for some without charge. If there had been greater efforts to vaccinate the public, particularly those at high risk, at $10 per individual, a substantial number of individuals who required hospitalization would not have needed it, and both the illness burden and economic costs avoided.

A public health approach to dealing with many health problems, rather than a focus solely on diagnosing and treating disease, offers considerable promise. If the candidates would give more thought to maintaining and improving the health of the public, and not focus exclusively on whether, or how, to pump more dollars into our traditional health services industry, the debates would enrich the public discourse and might generate changes in policy.

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LEGISLATIVE forum
Sourcebook, 1999 Edition
A guide to finding, evaluating and accessing sources of health data.

If you use health data in your job, you know how frustrating and expensive it can be to find the information needed to make intelligent, informed decisions about your market. This new, first-of-its-kind sourcebook from NationsHealth Corporation summarizes the information presented by a dozen of this country's most knowledgeable health data experts during workshops held in 1999.

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Come See Us on the WEB!

“Looks great! ... the added content will do much to enhance the site.”
– Robert Vogel, Managed Care, Sisters of Mercy Health System•St. Louis

“Impressive job! Both form and content are excellent! The site will become one of our regulars at the office.”
– Martha Bond, Executive Director, Finger Lakes HSA

“The web page looks fantastic! Thank you and great work!”
– Anthony L. Schlaff, MD, Harvard School of Public Health, Boston

“What a great pleasure to visit our newly-expanded web page! Not only are there more resources, but everything is better arranged ... By updating the page with such visual improvements, we are demonstrating ... a constantly improving organization.”
– John Steen, Community Health Planning, Columbus Health Department

After extensive discussion and creative thought, the AHPA Board has motivated a recreation of it’s web site, as depicted by the colorful blue and gold intro above (it must be seen first-hand at <www.ahpanet.org> to fully appreciate). As an added bonus, new activities and redesigned services are now available just by clicking one of the buttons shown below:
As if that isn't enough, communication will now be enhanced through the use of the American Health Planning Association "List Server" Electronic Network (AHPAnet for short) . . . this new service of AHPA is essentially an "electronic bulletin board service" which allows you to send a single message to a large group of people who have a keen interest in health planning issues. Just click on “AHPAnet Interactive” above to get there.

The intent of AHPAnet is to establish a running dialog among health planners in which you may participate, or simply observe, based on your time and needs. In either case, once you've subscribed, you will be able to observe the information exchange by simply viewing your regular email.

If you want to subscribe to AHPAnet, please go to our web site, click our button, and complete the form for Full Name/Title, Organization Name, Planning Activities, and Phone/Fax/Email. Your request will be processed promptly, and a notice sent to you when access has been established.

If you are already a subscriber to AHPAnet, and want to initiate a question or discussion, just create your message and email it to <ahpa@socket.net> ... that message will go to all AHPAnet participants. REALLY, its just that simple!!!

It is our goal to eventually involve all of our “email-empowered” AHPA members and many other health planners who have Internet email capability. This will provide an excellent opportunity to share information succinctly and quickly among planners and related organizations.

This experiment was authorized by the AHPA Board of Directors at its May 21, 1999, meeting in Richmond, Virginia, in an effort to improve communication. It is intended to be used on a daily basis.

Want to see who is on the Board? Just click on that button at our web site, see who and where, then send them a message just by clicking on their email address. Past articles and newsletters? Click on Health Policy Issues or Research Articles to review much of this past work, or plan for upcoming events announced at our Conferences/Mtgs button.

Something you want, and can’t find it? It is our goal to make AHPA and its communications vehicles as useful and rewarding as possible, so let us know what else is needed. **The practice of health planning is the core of our mission!!!**
AHPA Business Office
7245 Arlington Blvd., Ste. 300
Falls Church, VA 22042

First Class

ANNOUNCING

Hold Your Calendar!
for August 25-26, 2000

AHPA Education Workshop
on the Practice of Health Planning
San Francisco, California

Plans are being finalized, so visit our
website or call the AHPA business office
for updates and final scheduling.
At first, reflecting on the future appears to be an oxymoron. Reflection is often deemed to be looking back, as if we can only learn from past patterns. Or akin to looking in a mirror, in which we can only see what appears opposite the mirror.


So what’s in the report for us to reflect on?

• “The degree to which the nation tends to emphasize health care delivery rather than health” (a factor health planners have influenced only marginally!);
Under the best case, 30 million people remain uninsured; for those with insurance, tiering among eligibles will increase, resulting in generous benefits for some; limited or no choice of benefits for others; and uninsured or Medicaid, and with limited access to care; health status continues to be influenced by behavior rather than access (50% versus 4%); and health expenditures address access (88%) versus behaviors (4%).

The areas of inquiry reflect an expanded view of health:

- Public health;
- Patients, new consumers, and populations;
- Payers and health care costs; health plans and insurers;
- Hospitals, physicians and other providers;
- Care processes and medical management;
- Information and medical technologies; and
- The economic and legislative context.

The message from the futurists is that if you don’t want something bad to happen, get involved.

What’s this about Health Planning?
Who Cares for the Poor in St. Louis?
by James R. Kimmey

English is a complex language in which one word can have several meanings. Take “care” for example as used in the title of this essay. Care can mean “providing support and services,” or it can mean “having concern for”. In the case of health care, the answer to the question “who cares for the poor?” differs depending on the definition of care.

The list of those who “provide support and services” is much longer than rhetoric surrounding ConnectCare would suggest. In this community, multiple organizations are part of the “safety net” for health services. Religiously-based organizations, such as the Archbishop’s Commission on Community Health, support clinics and referral services for the uninsured. Area hospitals provide millions of dollars in uncompensated care annually. Federally supported clinics are an important element of the total picture, as are those operated by St. Louis County and by ConnectCare.

The problem ConnectCare faces — assembling enough financial resources to maintain a safety net of services for the uninsured and underinsured in the area — is symptomatic of a chronic problem in the larger society: lack of commitment to providing medical care to all.

Among the many solutions suggested to the directors of ConnectCare are:

- **The city should pay more. After all, the charter says it is responsible for the health care of the poor** — this suggestion was workable when the charter was written. The city was a strong economic force. The tax base was substantial. Health care was relatively simple and low cost. None of those factors is reality today. The city’s commitments have increased while its tax base has eroded. Health care has become increasingly complex and expensive. The current expectation — that the city will meet its commitment of $5 million annually — is realistic. Expecting substantially more from the city is not.

- **The state should make a greater contribution than it has been willing to so far** — the state manages the Medicaid MC+ program, as well as CHIPS, a program for children and their mothers. The state also administers a complex program for providing additional financial support to hospitals that treat a disproportionate share of poor patients. From the beginning of the ConnectCare program, the state has provided such funds to ConnectCare based on its operation of a small acute hospital. Whatever support the state can provide in the future must be provided in a manner consistent with state and federal legal authorities and rules. Barring new legislation, it won’t be enough.

- **The hospital systems have non-profit status and make lots of money. They should make up the deficits** — hospitals once could subsidize the care of the poor from the income generated by well-insured and paying patients. Today, limits imposed by managed-care companies and government programs have eroded the ability of hospitals to subsidize care for the indigent and uninsured. Despite financial pressures, hospital systems do provide substantial amounts of uncompensated care, and they have forgone part of the state’s disproportionate share payments so those funds could support ConnectCare. Continuing efforts by the federal government and third-party

*Continued on page 4*
Continued, from page 3
payers to reduce costs will further limit hospitals’ ability to maintain, much less expand, support of safety net programs.

• **ConnectCare should close its hospital beds and seek to become a federally qualified primary care provider** — this recent recommendation from a consultant provided by the state is under evaluation. Designation as a federally qualified health center would increase the amount of payment ConnectCare could receive for Medicare and Medicaid patients in primary care clinics and would eliminate its dependence on state disproportionate share hospital funds. While this might materially assist the primary care clinics, it would not adequately support the speciality clinics or hospital services for the uninsured clients currently using ConnectCare. The state’s consultant proposed no solution to the latter problem other than to pass it on to hospitals and physicians. That strategy is subject to the limitations cited earlier.

• **ConnectCare just needs to hold out until the tobacco settlement is final. That will provide stable funding** — the settlement money is substantial but many steps have to be taken before funds might become available to ConnectCare and other safety net programs in Missouri. Although these funds may support indigent care in the future, neither the amounts that might be available nor the means of distribution are known. ConnectCare cannot count on tobacco funds particularly in the immediate future.

• **Indigent care needs a dedicated sales tax** — this possibility has been raised several times, most recently by Comptroller Darlene Green, as a way of providing a stable funding base for ConnectCare and its safety net programs. Its attractions are many: It imparts stability, meets the city’s charter obligation to provide health care to the underserved, and removes the funding from the city’s annual budget process.

Politically, it has substantial problems. Sales tax increases are never popular unless they deal with clearly defined issues with which voters can personally identify. Efforts to deal with health insurance or health programs for the most vulnerable members of society in this country have a dismal history. This suggests a hard road for the sales tax approach, despite its attractiveness from ConnectCare’s perspective.

There you have it – loads of suggestions, few solutions. ConnectCare is committed to preserving comprehensive services for the uninsured and underinsured in the community. The directors will do what is required to maintain effective programs, drawing on every potential source of funds and striving to make operations as efficient and cost effective as possible. But that goal cannot be achieved without broad support in the community. Support that is expressed through adequate funding for services to those without financial means or insurance. ConnectCare care for the uninsured. Does St. Louis care?

James R. Kimmey, M.D., is Executive Vice President of the St. Louis University School of Medicine and Chairman of St. Louis ConnectCare.

This commentary appeared in the March 27, 2000 edition of the St. Louis Post Dispatch. It is reprinted with permission.

Continued from page 3
• **Identify clear, achievable goals for students.** Since most students will be involved for only one academic term, projects should be of manageable scope. Ideally, students will be able to see the fruits of their labors and deliver a finished product to the agency. Students can often explore specialized, but important topics that time pressures or short staffing have pushed onto an agency’s “back burner.”

• **Frequent communication with students and faculty is vital for success.** Different expectations and miscommunications can be a particularly difficult challenge in student-faculty projects with a short time frame. This is particularly important in the initial selection of students and/or faculty for collaborative projects. Academic departments whose faculty have considerable experience with survey research, for example, may or may not be well versed in cost/benefit analysis or other tools needed to address an agency’s needs.

• **In designing and implementing survey instruments, adequate “pilot testing” is essential.** A “dry run” of a survey administered to carefully selected groups of providers, patients, or staff can uncover potential problems.

• **Although it may be tempting to utilize student help for routine office tasks, students should not be viewed as an antidote for short-staffing.** Internships, in particular, are a two-way street. While agencies properly view students as a resource, student projects should be educational and should assist participants in clarifying their values and career goals.

• **Mentoring.** Last, but certainly not least, is the importance of carving out time to discuss projects with students and faculty. Reflecting on how decisions were made, or how processes should be designed to maximize public input, provides a stimulating exchange of ideas.
Health planners and policy analysts are well aware of the correlations between health care capacity and service utilization, as well as between utilization and cost. Researchers ranging from Milton Roemer in the 1960s ("a bed built is a bed fill’l") to John Wennberg today ("geography is destiny") have demonstrated that much of the unwanted variation in hospitalization rates, use of procedures, and intensity of care is directly attributable to the differences across geographic areas in both beds per capita and physicians per capita. Research has also demonstrated that, for certain conditions, treatment options are frequently chosen without strong theoretical foundation; often, those choices are influenced by the presence or absence of excess physician or bed capacity. The resulting practice variations affect the overall costs of care and can influence clinical outcomes, as well.

Traditionally, health planners have utilized the Certificate of Need (CON) process to try to ensure that the health resources in a given community reflect the need of the population and not simply the aggregate wishes of individual institutions or interest groups. While CON has been effectively used in some parts of the country, most analysts agree that its overall record in controlling costs and ensuring access is decidedly mixed.

Within the last decade, many states have abandoned or diluted CON in favor of a more competitive strategy to try to bring desired efficiencies to health care. The “market” – so goes the argument – will ultimately “right size” the system because health care providers will be unwilling or unable to invest in unneeded services. While this approach may ultimately prove effective, in the short term it does not appear to be controlling overall costs. In fact, many areas of the country are experiencing a surge in costs as individual institutions and systems jockey for market share. As costs have increased to unprecedented levels, many insurers have responded by aggressively managing the utilization of their subscribers. This in turn, results in an increase in denials, more frustration on the part of physicians, and a public increasingly hostile toward managed care.

Given the limits of both CON and the market, is there an alternative way to address unwanted variations in health care capacity, utilization, and ultimately, costs? Perhaps. Several communities are turning to "capacity management," a kind of private sector health planning. Kaiser Permanente, the staff model HMO based on the West Coast, for instance, consciously controls both the number of physicians it employs and the size of its investment in acute care hospitals. Rather than micromanage individual clinical decisions, Kaiser relies on a limited resource to manage utilization; the HMO knows that the threshold for hospitalization is higher when the supply of beds is limited.

In Rochester, New York, where two insurers account for more than 85% of all commercial policies, a volunteer panel, call CTAAB — Community Technology Assessment Advisory board — evaluates and makes recommendations regarding coverage policy to the insurer. This mechanism helps ensure that appropriate technology is provided at capacity sufficient to meet, but not exceed, the needs of the community. The larger of these insurers is also developing a process whereby its reimbursement for all new services will take into account need recommendations made to it by the local planning agency. Thus, local assessments of community need, rather than the state’s ineffective CON process, will influence coverage decisions for this commercial insurer. Community leaders are being drawn into the design of this new capacity management process and briefed on its value to the community.
New Ethics for the Public’s Health
Edited by Dan E. Beauchamp and Bonnie Steinbock.
Oxford University Press, 1999
Reviewed by John Steen, Director,
Community Health Planning, Columbus (Ohio) Health Department

This book is a collection of 29 readings, previously published as journal articles or book chapters, chosen by the editors to represent the range of ethical and philosophical issues that challenge public health today. Organized under nine major topic headings, the sequence of readings ultimately provides an introduction to the philosophy of public health.

The editors provide an introductory synopsis of moral philosophy and ethical theory as they relate to public health, then introduce each section with a discursive overview which identifies the issues covered and provides a context for seeing how the selections fit into the overall story of public health.

Teaching by example, the readings illustrate the unique perspective and methods of public health and provide tools for conceptualizing macroethical issues in their social and political contexts as matters of public policy. The strength of this approach is to make accessible a set of readings representing paradigms of reasoning on key public health issues, not polemics. These are highlights in the literature of public health, written between 1972 and 1997, that deserve to be well known to, and appreciated by, its practitioners.

“Never send to know for whom the bell tolls; it tolls for thee.” – John Donne

Here is Amy Gutmann on access (1981):

Equality of opportunity, equal efforts to relieve pain, and equal respect are the three central values providing the foundation of support for a principle of equal access to health care.

And Dan Beauchamp on justice (1976):

The central implication of the view set out here is that doing public health should not be narrowly conceived as an instrumental or technical activity. Public health should be a way of doing justice, a way of asserting the value and priority of all human life. The primary aim of all public health activity should be the elaboration and adoption of a new ethical model or paradigm for protecting the public’s health ....

The adoption of a new public health ethic and a new public health policy must and should occur within the context of a democratic polity. I agree with Terris that the central task of the public health movement is to persuade society to accept these measures.

And the late Jonathan Mann on leadership for human rights (1997):

The official nature of much public health work places public health practitioners in a complex environment, in which work to promote rights inevitably challenges the state system within which the official is employed.... And as public health seeks to “ensure the conditions in which people can be healthy,” and as those conditions are societal, to be engaged in public health necessarily involves a commitment to societal transformation....

That this work — added to, not substituted for, the current approach of public health — will require major changes in public health reflection, analysis, action, and education, is clear. That it is urgently required, in order to confront the major health challenges of the modern world, is equally clear. . . .

Continued on page 9
The Illinois General Assembly recently passed Senate Bill (SB) 807 and has forwarded the bill to Governor George Ryan for action. SB 807 would make major revisions to the Illinois Certificate of Need (CON) program. Illinois’ CON program was enacted in 1974 and has been revised on several occasions after the National Health Planning and Resources Development Act was repealed in the 1980s. The Illinois program presently requires that a permit (CON) be obtained prior to significant construction or modification of health care facilities and prior to the acquisition of major medical equipment. Facilities that are subject to CON requirements are hospitals, long-term nursing care facilities, ambulatory surgical treatment centers, and kidney dialysis treatment facilities.

Illinois’ law currently requires that the Health Facilities Planning Board, a 15-member commission that is staffed through the State Department of Public Health, review and issue permits or exemptions for proposed projects for the acquisition of major medical equipment (diagnostic and treatment equipment) that cost in excess of $1.3 million, for any capital expenditures in excess of $82.7 million, for substantial increases in bed capacity, and for a substantial change in the scope of a facility’s operation such as the initiation or discontinuation of an institutional health service.

The statutory changes proposed by SB 807, which passed by a nearly unanimous vote in both houses of the General Assembly, include major revisions to the CON statute. The most significant change proposed by the pending legislation is a repeal of the CON law on July 1, 2003.

The amendments also propose raising the capital expenditure review threshold to $86 million for major medical equipment and for all other capital expenditures with the exception of expenditures for health and fitness centers. The capital expenditure review threshold for health and fitness centers would remain at the current $82.7 million. The expenditures would be adjusted annually for inflation. In addition, the changes propose to remove from review all expenditures that are made by or on behalf of health care facilities if the expenditures are for non-clinical service areas. A non-clinical area is defined as an area for the benefit of patients, visitors, staff, or employees of a health care facility that is not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. Examples of such areas include: computer systems, dining areas, parking facilities, educational facilities, administrative areas, life safety code projects, and mechanical systems. Another type of project that would be exempted from review would be any capital expenditure made by or on behalf of health care facility for the construction or modification of any facility that would be licensed as an assisted living facility.

The sole change which would extend CON’s jurisdiction is a provision that would require “out-of-state facilities” to be subject to obtaining a permit for construction or modification of any institution, place, building, or room located in Illinois that would be used for the performance of outpatient surgical procedures. The Governor signed the bill on June 9 and it became effective immediately. Upon enactment, the Auditor General of Illinois is to commence an audit of the Health Facilities Planning Board to determine several effects of the CON program, including whether the Planning Board can demonstrate that the CON process is successful in controlling health care costs, allowing public access to necessary health services, and guaranteeing the availability of quality health care to the general public.

Other changes proposed include a section on ex parte communications that defines such communications and specifies what type of communications are prohibited and the process for reporting such contacts. Technical assistance provided by staff to applicants is permitted under this section; however, such assistance must be documented in writing by the applicant and by staff within 10 business days after the assistance was provided.
# American Health Planning Association 2000 Workshop

## Community Health Benefit:
Innovative Policy and Planning Initiatives

**Friday, August 25, 2000**

Ramada Hotel, San Francisco International Airport North, South San Francisco, California

## WORKSHOP AGENDA

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<tr>
<td>8:30 am</td>
<td>Final Registration and Continental Breakfast</td>
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<tr>
<td>9:30 am</td>
<td>Welcome and Introductions</td>
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<td><strong>Robert R. Vogel</strong>, AHPA President</td>
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<tr>
<td>9:45 am–11:30 am</td>
<td>Community Benefit in Health Care: Practice and Implications</td>
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<td><strong>Kevin Barnett</strong>, Principal Investigator, Public Health Institute</td>
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<td>on the concept, history, practice, principles, public/private shared accountability, sustainability, and examples from his experience.</td>
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<tr>
<td>11:45 am</td>
<td>Lunch <em>(served as part of workshop)</em></td>
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<td>12:45 pm</td>
<td>Innovation in Health Planning: Hawaii’s Model Approach</td>
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<td><strong>Marilyn Matsunaga</strong>, Admin., Hawaii Health Plng &amp; Dlpmt Agency</td>
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<td>on how Hawaii moved from regulating resources to regulating adherence to their health outcomes plan, including how it was done and the politics involved.</td>
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<tr>
<td>2:00 pm</td>
<td>Audience Dialogue: Developing Effective Policy</td>
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<td><strong>Kevin Barnett</strong> and <strong>Marilyn Matsunaga</strong></td>
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<td>an interactive discussion on a series of key questions arising from the presentations plus burning issues of the day for workshop attendees.</td>
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<tr>
<td>3:15 pm</td>
<td>Adjournment/Social Hour <em>(opportunity to informally meet, network and share ideas)</em></td>
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<tr>
<td>4:00 pm</td>
<td>AHPA Board Meeting <em>(until 06:00 pm Friday, plus 08:30–noon Saturday)</em></td>
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## REGISTER NOW

☐ $70.00 registration fee *(includes continental breakfast, lunch, and breaks)*

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This textbook represents a resource in improving public health education and thereby developing a more professional workforce with a unified vision of the role of public health in society and its own set of public health ethics. The ongoing marginalization of public health in American society will never be reversed without the leadership and policy advocacy of all who work within it.

We are called upon to market a truer vision of our society and its core values than that offered by market individualism. Fortunately, we have here some of the analysis, wisdom, and inspiration we will need to do it.

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**Biographical Sketch of Marilyn Matsunaga**

Marilyn Matsunaga is the Administrator of the Hawaii State Health Planning and Development Agency (SHPDA) where she sets the strategic vision for the Hawaii Health Performance Plan, renders certificate of need decisions, analyzes the community's utilization of health care facilities/services, and oversees the planning direction of community-based health planning councils statewide. During the summer of 1998, she served as co-chair of Hawaii's project with Vice President Gore's Office called the National Partnership for Reinventing Government. This year, Governor Cayetano asked her to head up the areas of health tech and health biotech as a member of his office's "virtual" tech team.

She has served as the Special Assistant to the Governor for health care and human services. She was also the Special Assistant to the Director of the Health Department facilitating the management of the state's 12 public hospitals.

Ms. Matsunaga has also served on the Board of the National Public Hospitals Association, the Steering Committee of the Hawaii Literacy in Action Academy, Aloha United Way Allocations Panel II and other non-profit organizations. She has spoken across the country on Hawaii's near universal access health care system.

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**Biographical Sketch of Kevin Barnett, Dr.P.H., M.C.P.**

Kevin Barnett is a principal investigator for the Public Health Institute (PHI) in Berkeley, California. His work with the PHI focuses on applied research and technical assistance in areas such as population health planning, policy analysis, and community problem solving.

A major recent focus has been research into the role of not-for-profit health care organizations in community health improvement. Early research led to the publication of a monograph on community benefit theory and practice including a review of state legislative initiatives in 1995. The second monograph, entitled The Future of Community Benefit Programming outlines a conceptual framework and a typology for planning and assessing hospital participation in community health improvement activities.

The primary focus of Kevin's current work is to conduct applied research and provide technical assistance to health care, public health, and community stakeholders. Examples of private sector clients include the Champaign County (IL) Health Care Consumers, Catholic Healthcare West, the New Hampshire Hospital Association, the Via Christi Health System, and the St. Joseph Health System. Examples of state agencies include the New Hampshire Department of Health Services and the California Office of Statewide Health Planning and Development.

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**Recent Data Releases**

NationsHealth Corporation has announced that county-level behavioral risk factor information is now available through their QuikStats on-line service at <http://www.nationshealthdata.com/>.

Dr. Richard Thomas, President of NationsHealth, says this data warehouse is partially funded by the National Institutes of Health. It has been created through the integration of dozens of existing health-related and demographic data sets.

NationsHealth also publishes books for health data professionals, including two recent releases: *Health Data Sourcebook* and *Health and Healthcare in the United States, County and Metro Area Data*.

Additional information on these publications is also available on their Web site.
Various industry observers have pointed out the transformation that has taken place in health planning over the past several years. The form of planning that has emerged as a component of healthcare in both the public and private sectors is a far cry from the comprehensive planning approach pursued during the 1960s and 1970s. The healthcare environment has changed dramatically, mandating a new approach planning for both government health agencies and private sector providers.

The evolution of a new planning approach is being driven by changes in the healthcare system itself, particularly in the realm of decision making. Unlike the past when things changed slowly, the healthcare industry is undergoing rapid transformation and decisions that affect the survival of the organization frequently must be made. These decisions are increasingly data driven, requiring the background information that planning analysts must provide, and, in order to be appropriately made, this process must have a context—i.e., a plan — within which to make the decision.

The decision-maker’s role has evolved in healthcare from routine administration to frequent career-influencing judgments, from a situation of little accountability to one of extreme accountability, from an internally-driven decision-making process to an externally-driven one, and from a “seat-of-the-pants” approach to one that is technically-driven. Finally, while the course of action for a healthcare organization in the past may have obvious to anyone, today’s healthcare organization, whether public or private, faces many options.

All of this means that the nature of the decision maker is changing. The role of decision maker is shifting from one of manipulator to questioner, from demander to pleader. In fact, a new breed of decision makers has emerged in healthcare, a new generation that is better trained, more street savvy, more technically-oriented, more open-minded, and less encumbered with “baggage” from the past. This new administrator is much more likely to “think outside the box” than the old-line decision maker.

Despite the fact that today’s healthcare administrators may be better equipped to deal with a dynamic environment than their predecessors, they of necessity will increasingly make demands on planners that exceed any known in the past. Decision makers need quick answers when long-term analysis is invariably required, short answers when extensive details are necessary, simple answers when the situation is very complex, certain answers when the environment is changing every hour, and focused answers when every situation has multiple dimensions.

Just as this situation creates a demand for a new approach to planning, it creates the need for a new type of planner. Historically, the health planner has served as a technical resource at best, seldom offering more than background information and possible options for disposition by the decision maker (if not some intermediary). The planner seldom was involved in discussions involving strategy on the front end or on implementation on the backend. As such, the role of the planner — despite lip service to the contrary — was minimized. Today’s health planner must now take on a number of new roles. These roles include:

**Issue Formulator.** The healthcare environment has become so complex that even (perhaps especially) the veteran administrator cannot grasp its full measure. While it is probably a truism that administrators typically did not ever know what the real issues were for a planning initiative, that maxim is even truer today. The apparent issues are seldom the real issues, and substantial effort is required to identify the most salient issues related to any decision and focus the decision maker on them.

**Background Briefer.** Historically it was assumed that the decision maker knew as much or more about the healthcare environment and any issues at hand as anyone else. While that was possibly true in the past, no one human being can know everything that one needs today about the current healthcare environment.
There are aspects of healthcare that did not exist five years ago, new components are constantly being added to the healthcare system, and the reach of healthcare has extended into areas where the industry has never before ventured. The planner must know more about the topic than the decision maker and be able to provide the background information necessary to grasp the situation — well before any decision can be considered.

**Interpreter.** Nothing is the way it used to be in health care and most things are not what they seem. Health care has become increasingly complex and the ability to interpret situations, activities and development in the environment is critical. Planners must be able to answer “what does this mean?” questions and provide appropriate analysis of phenomena both within and outside the organization. The ability to convert data into information and, ultimately, information into solutions rests more and more on the planner.

**Criteria Specifier.** Virtually every decision in healthcare today involves a choice among options, even if one of those options is to do nothing. The bewildering number of possibilities creates a dilemma for the decision maker who has a limited perspective for differentiating between options and prioritizing the best ones. The planner must be able to establish criteria that provide a basis for making these distinctions. These criteria, of course, should be linked to the strategic plan of the organization and the planner is in the best position to convert strategic initiatives into meaningful criteria for use by the decision maker.

**Implications Identifier.** Every decision has complications and quite often the unintended consequences are more significant than the intended ones. The planner must be able to identify the implications of any decision to the extent possible. These implications may extend far beyond the immediate clinical context, beyond the institution and into the community. Given the potential negative fallout from a poorly thought-out decision, identifying the implications of a particular decision or set of decisions becomes one of the most critical steps in the planning process.

**Data Collector/Analyzer.** It goes without saying that data collection and analysis are major responsibilities of a planner in the planning process. The importance of this process is even more noteworthy than in the past, and increasingly sophisticated methods of data collection and analysis must be adopted by the planner. Further, the ability to link this “technical” aspect of the process to the other roles specified here is critical. The data supporting a planning effort cannot be seen as a separate body of knowledge, but must be integrated with each of the other components of the process.

**Scenario Depictor.** The health care environment has become so complex that even the best informed decision maker cannot be knowledgeable about all aspects. Further, it is often difficult to explain a concept or situation adequately due to this complexity. The planner must become adroit at developing scenarios that depict the phenomenon in question. A scenario should lay out by means of example the players, activities, processes, and outcomes associated with a particular initiative. This is the planning equivalent of the picture that is worth a thousand words.

**Decision Maker.** Finally, and perhaps most importantly, the planner is increasingly being asked to play a more proactive role in the decision-making process itself. In the past, a mere planner would not be allowed anywhere near the decision; the administrator knew more than everyone else anyway. That situation clearly is not true today and even providing the decision maker with the best three options for his or her disposition may not be adequate. Increasingly, the planner is being told to come up with the one best choice — in other words, to make the decision. This is not a role that most planners are comfortable with but, for better or worse, the current environment will increasingly put the planner in the role of decision maker.

The roles that the contemporary health planner is being asked to perform are clearly different from those that existed under any traditional community planning approach or in planning departments of private sector healthcare organizations. The dramatic transformation of healthcare and its ongoing condition of dynamic change call for non-traditional approaches. The decision making process is now much different than in the past and this new situation calls for a new type of health planner who carries out a number of functions totally alien to his or her forebears.
First Class

Hold Your Calendar! for August 25, 2000

AHPA Workshop
Community Health:
Innovative Policy and Planning Initiatives
San Francisco, California

See page eight for additional details concerning registration and agenda
The President’s Column

PHI Public Trust Model®
Robert R. Vogel, Vice President, Managed Care
Sisters of Mercy Health System • St. Louis

AHPA’s August workshop focused on community benefit. Kevin Barnett, principal investigator, Public Health Institute (PHI), presented a detailed program covering theory and practice, as well as history, trends and implications. The PHI Public Trust Model® for assessing expectations of organizations deferring taxes describes the following components:

- **Redistributive intent**: to areas and populations in need;
- **Special skills/capacity**: concentration in proximal communities;
- **Efficiency/surplus value**: efficiently allocated and leveraged resources;
- **Protection from political influence**: protected from general fund debates;
- **Collaborative governance**: structure and process reflecting stakeholders; and

Continued on page 2

Inside this Issue . . .

- PHI Public Trust Model
- Health Planning Focus
- With Liberty and Justice for All?
- Finding Opportunities in Medicare’s New System
- What’s the Future of CONP in Virginia?
- HHS Awards Grants to 11 States
- U2K?
- Improving Services to the Uninsured
• **Pluralism/flexibility**: higher innovation than centralized public programs.

Such organizations may or may not have planning models and processes that effectively address these components. There is also a question as to whether such organizations consider revenues received subject to some of these expectations, such as redistribution to geographic areas or populations, if externally defined. A health planning challenge arising from this discussion of community benefit is how community needs are incorporated into individual organization decision-making about how they meet their community benefit obligations.

In the public arena more familiar to health planners, population needs, capacities at the proximate community level, resource allocation, collaboration and innovation are familiar expectations. In reality though, aren’t we experiencing some of the same decision-making isolation and disconnection from community health care issues that one may see among private non-profit organizations?

How are public monies to be effectively employed to meet defined needs in an efficient manner seeking flexibility and innovation if there is no coordinated plan or planning process?

If nothing else, health planning skills should be in high demand among both public and private non-profit organizations. If so, at least these organizations would approach their obligations individually in the best possible way, short of community-wide health planning and resource allocation — if that ideal is not possible.

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**Health Planning TODAY**

*a periodic publication of the American Health Planning Association*

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Information for the quarterly journal is due on March 1, June 1, September 1, & December 1. Articles should be short — no more than one page of text. The editor reserves the right to edit any article or submission as needed.

Information may be submitted via e-mail to: “dschuess@mail.state.mo.us” or “tpiper@mail.state.mo.us” or faxed to (573) 751-7894.

Donna Schuessler, Editor
With Liberty and Justice for All?
by John Steen, Director
Community Health Planning, Columbus (Ohio) Health Department

On June 20, 2000, the World Health Organization (WHO) issued an unprecedented report on all of the world’s health systems, the first report card to the world’s peoples on their health care.

The World Health Report 2000 - Health Systems: Improving Performance is a milestone in the global institutionalization of performance assessment, reflecting two years of work by hundreds of physicians, economists, statisticians, demographers, and anthropologists. It does nothing less than challenge us to redefine our thinking about what a health system is, and to extend that thinking beyond the provision of public and personal health services so as to encompass other areas of public policy that influence population health.

The report breaks new ground in the very way it defines the goals and functions of health systems. The new WHO framework focuses on three key goals of health systems:

- **Achieving good health** in a population both by raising its overall level and by improving its distribution among the population;
- **Enhancing the responsiveness** of a health system to a population’s needs and expectations; and
- **Assuring fairness** of financial contributions so that every household pays a share of the country’s health bill based on their capacity to pay.

And it describes four key functions:

- **Providing services**;
- **Generating the physical and human resources** that make service delivery possible;
- **Raising and pooling the resources** used to pay for health care; and
- **Stewardship** — setting and enforcing the rules of the game and providing strategic direction for all the different actors involved.

In designing the framework for health system performance, WHO innovates by employing a technique not previously used for health systems. It compares each country’s system to what the experts estimate to be the upper limit of what can be done with the level of resources available in that country. It also measures what each country’s system has accomplished in comparison with those of other countries.

The index of indicators used by WHO to measure performance is a reflection of a consensus that grew out of the results of surveys conducted on thousands of people in dozens of countries. For example, WHO found near universal agreement that out-of-pocket payment at the time of illness is an undesirable and unfair way of financing health care.

WHO’s assessment system is based on five indicators:

- Overall level of population health;
- Health inequalities (or disparities) within the population;
Continued from page 3

- Overall level of health system responsiveness (a combination of patient satisfaction and how well the system acts);
- Distribution of responsiveness within the population (how well people of varying economic status find that they are served by the health system); and
- Distribution of the health system’s financial burden within the population (who pays the costs).

It is important to recognize that WHO’s vision of the mission and performance of the world’s health systems incorporates a defining ethic, one that might be characterized as social justice through fairness. It is the paradigm of fairness that drives three of WHO’s five performance indicators. Fairness, as a fundamental ethical concept, is broadly applicable throughout a society. Here, its application to health systems includes measures of equity, efficiency, accountability, and autonomy: Equity in outcomes, access, and financing; efficiency in management and allocation; accountability to the public interest through public decision-making, public reporting, and public empowerment; a measure of autonomy for patients and providers.

The Rankings

The United States spends more on health than any other nation. The WHO's rankings assess the results in both absolute achievement and achievement relative to expenditures.

With regard to WHO’s five key indicators for goal achievement by health systems, the United States ranks as follows:

- **Level of Health** (DALE: Disability - Adjusted Life Expectancy): 24
- **Fairness of Health** (Distribution of life expectancy across populations): 32
- **Responsiveness** (Patient perception of the quality of health care): 1
- **Fairness in Responsiveness** (Equality of responsiveness across groups): 3
- **Fairness in Financing** (Affordability of health care across groups): 54

What may be viewed as its greatest achievement to date is WHO’s development of a composite index of overall health system goal attainment.

Over one thousand public health practitioners from over 100 countries were surveyed in order to construct a weighted index of the above five indicators. The weights on the five individual components are:

- 25% level of health;
- 25% distribution of health;
- 12.5% level of responsiveness;
- 12.5% distribution of responsiveness; and
- 25% fairness of financial contribution.

On this composite measure, the United States is ranked 15.

The WHO Report does not judge countries on how much they choose to spend on health, but does measure their relative achievement for whatever they do spend. Two health performance measures are thus measured for their efficiency. In one ranking, overall goal attainment (as explained above) is related to expenditures for health. In this, the United States ranks 37. In the other ranking, each country’s achievement in health (DALE) is related to what might have been achieved through the most efficient health system results achievable for the country’s actual per capita health expenditure. In this, the United States is ranked 72.

The WHO will continue to produce reports annually which will measure the performance of the world’s health systems through indices that will be continuously improved and updated.

**Stewardship**

The many, and provocative, implications of the WHO Report are obvious to anyone who views population health as a function of justice in a social and political context. Dr. Gro Harlem Brundtland, Director-General of the WHO, points out that “…the overall effectiveness of government seems to have a particularly strong influence on health systems performance,” and that “the careful and responsible management of the well-being of the population — stewardship— is the very essence of government.”

This is the “moral” of this story, and the Report can be described either as an outcome-based performance assessment of the world’s health systems, or as an assessment of the extent to which the world’s health systems are neglecting their responsibilities for stewardship.

Continued on page 5
And what is stewardship but good planning and intelligent regulation?

The WHO’s conception of stewardship involves three key functions:

- Setting, implementing, and monitoring the rules for the health system;
- Assuring a level playing field for all actors in the system (particularly purchasers, providers, and patients); and
- Defining strategic directions for the health system as a whole.

These functions of stewardship can be subdivided into six sub-functions:

- Overall system design;
- Performance assessment;
- Priority setting;
- Intersectoral advocacy;
- Regulation; and
- Consumer Protection.

“Intersectoral advocacy” refers to the promotion of policies in other social systems, e.g., education, that will advance health goals.

Social Justice

One of the most salutary lessons this Report teaches us is that the effectiveness of health systems is determined by the social and political determinants of population health “upstream” from health care. And we should see this Report as an important contribution toward a world consensus that ensuring the conditions in which people can be healthy is a human right. It directs us all to seek out the societal root causes for poor health, and to provide solutions through the structural improvement of society itself.

Properly, this raises some very great questions that we are all called upon to answer. Improvement in health status equality will not be achieved without improvement in social cohesion and reduction of income inequalities, for these determine, in turn, our feelings of self-worth and our levels of social anxiety, two major psychosocial determinants of population health.

As I write this, eight weeks have passed since the WHO Report was issued, and one must remark on the under-reaction to it in the media. One would think that its findings must not be relevant to our country. Rather, we should add to its significance the evidence it offers of the depreciation of public life and our loss of a moral compass within it. It is telling us that we live in an increasingly dysfunctional society, one that fails to promote health achievement for all of its members because it fails to respect the lives of all of its members. It shows us a failure in our democracy that abrogates what is even more essential to human rights than health:

Nurturing a shared sense of the intrinsic value we all have as members of one community.
Finding Opportunities in Medicare’s New System
by Karen Cameron, CHE, Vice President
Data Resource Management, Inc., Richmond, VA

While designed to be budget neutral for the federal government, the Health Care Financing Administration’s (HCFA) new outpatient prospective payment system (PPS) for Medicare beneficiaries, based on the ambulatory payment classification (APC) system, will effect the profitability of each facility and its various services differently. This system, which took effect August 1, 2000, will represent a major change to the current system, similar to the effect DRGs had on inpatient care.

Hospital and ambulatory surgical center payments and beneficiaries' coinsurance will be based on national (adjusted for geographic wage differences), rather than facility-specific, charges for all outpatient services (based on an ICD-9-CM diagnosis) not already covered by another Medicare fee schedule. Multiple procedures that occur in the same visit will be discounted, with facilities receiving the full payment for the highest paid procedure and the remainder being paid at 50% of the payment rate. Moreover, observation payment will be bundled into the payment and there will be “pass-through payments” for specific devices identified by brand on HCFA’s website: <www.hcfa.gov/medicare/passthru.htm>.

The American Hospital Association, while strongly suggesting evaluation of specific organizational effects, projects that patients of hospitals that historically have had lower than average charges, such as rural providers, will probably see increases in their coinsurance while these lower charge hospitals may experience overall payment increases. The opposite is expected at historically higher charge providers, typically in urban settings. However, HCFA has requested that hospitals not collect deductibles or coinsurance from beneficiaries until the agency notifies hospitals of the correct amount. Moreover, HCFA will be paying hospitals part of any losses from the current system (all losses will be paid to hospitals with less than 100 beds) during the changeover, allowing some critical time for hospitals to prepare for this significant change.

Understanding the procedure-specific impact of APCs will be necessary for hospitals and ambulatory surgery facilities to identify the likely effect of this new PPS system. Some of the financial and market issues facilities should address include:

- Which services/product lines should be targeted for development?
- Which services, if any, should be offered at lower Medicare coinsurance payments (effective January 1, 2001) to foster specific market development?
- How should any significant changes in coinsurance be communicated to patients or Medigap insurers?
- Which services should be examined to identify opportunities for cost savings or referral to another provider?
- How do I ensure that physician orders have the necessary payment information?
- How do my APC rates compare to those currently received from my major private payers and how might my next contract negotiation be effected by it?
- Do I have any facilities which will require a “provider-based determination” from HCFA before the October 10, 2000 deadline?

Public health planners should understand the potential ramifications of the new system, and facilities’ reaction to the new systems reimbursement, on community health services. Among the possible issues are:

- If some higher-cost services are referred to one facility, how does that affect patient’s geographic access, quality of care, and cost to the public?

Continued on page 8
What’s the Future of COPN in Virginia?
by Karen Cameron, CHE, Vice President
Data resource Management, Inc., Richmond, VA

Based on Senate Bill 337, passed during last year’s legislative session, Virginia’s Joint Commission on Health Care (JCHC) is busy trying to develop a plan to phase out Certificate of Public Need (COPN) beginning on July 1, 2001, and ending by July 1, 2004. The plan will only go into effect after the Virginia General Assembly has voted on it at the 2001 session that begins in January. As they say, “the devil is in the details.”

With only five months left, the JCHC’s Chairman, State Senator Bill Bolling, and its Executive Director, Pat Finnerty, are working to bring the various stakeholders together to develop a plan that would not be circumvented by the many lobbyists that represent the numerous interests involved (including hospitals, physicians, nursing care facilities, specialty health care companies, insurers, and consumers). The following are among the many issues the plan is suppose to address:

- Access to care for indigent persons;
- The health care needs of uninsured persons;
- Establishing licensure standards for deregulated services to protect public health and safety;
- Providing adequate oversight of deregulated services to protect public health and safety;
- Monitoring the effects of deregulation on the number and location of medical facilities and projects;
- Determining the effect of deregulation on long-term care facilities, new hospitals, academic health centers, and rural hospitals which are critical access hospitals; and
- The impact on state-funded health care financing programs and the fiscal impact of deregulation on market rates paid by health and long-term care financing programs.

Continued on page 8
The two states that eliminated CON during the late 1990s, Ohio and Pennsylvania, both implemented new types of health care regulations. Nebraska has begun a study of issues raised by its recent partial repeal of CON, including the increasing number of outpatient surgical facilities and the need for information about these services.

As a part of their efforts to develop an appropriate plan to deregulate, the JCHC staff reviewed the status of Certificate of Need (CON) regulation in other states and, if CON had been eliminated, how deregulation had occurred and its effects. The staff found 13 states had entirely eliminated CON (most in the 1980s with the elimination of federal funding for CON programs). Four states only had CON for long-term care. Seven states had somewhat limited CON review, while two of three other states that recently reviewed their CON programs made significant changes.

While Ohio has had $700 million in capital expenditures (almost entirely in metropolitan areas) over the last 2 1/2 years – including about 80 ambulatory surgery centers, 50 imaging facilities, and 6 open heart surgery programs – Pennsylvania has had some open heart surgery units and an initial proliferation of hospital-based long term care units that has since dropped off. Pennsylvania has enacted new regulations for health facility licensure, while Ohio has enacted quality assurance regulations for many acute care services and licensure standards for free-standing facilities.

The JCHC staff concluded that, because most states that eliminated CON did so in the 1980s without any oversight systems to provide information concerning repeal effects, and because there are substantial demographic differences between Virginia and these states, there appears to be few guides for eliminating CON through use of a comprehensive planning model. Moreover, many that eliminated their programs in the 1980s cite the need for a monitoring role through targeted data collection and analysis.

Based on my experience with Virginia’s legislature and CON, I expect that Virginia’s plan will represent a compromise of the many interests involved and will likely include:

- Alternative regulations to ensure public health and safety;
- An indigent care contribution plan;
- Continuation of COPN review of nursing care facilities and perhaps new hospitals; and
- A data collection and monitoring program.

No one is likely to be particularly happy with the plan, but it will represent potential opportunities for some, and concerns for others. That will require careful evaluation to avoid longer-term financial and patient care problems. Of course, the real issues are whether the compromise will be agreeable enough to all those concerned to get through the General Assembly and what health care delivery problem(s) Virginia is trying to solve through deregulation of COPN.
HHS Awards Grants to 11 States to Develop Plans
Giving All Citizens Access to Health Insurance

HHS Secretary Donna E. Shalala announced today that eleven states have received one-year federal grants totaling $13.6 million to develop plans for providing their uninsured citizens access to affordable health insurance.

Under the new State Planning Grants program, administered by HHS’ Health Resources and Services Administration (HRSA), grantees from state agencies first will conduct studies to better identify the characteristics of uninsured citizens. The grantees – from Arkansas, Delaware, Illinois, Iowa, Kansas, Massachusetts, Minnesota, New Hampshire, Oregon, Vermont and Wisconsin – then will use that data to determine the most effective methods to provide them with high-quality, affordable health insurance similar to plans that cover government employees or other benchmark plans.

“These grants are a vital step in the Clinton-Gore administration’s ongoing effort to provide access to quality health care for all Americans,” Secretary Shalala said. “It is the latest example of how steady, incremental progress moves our nation closer to that goal. Strong interest among states for the planning grants reflects the importance of the administration's efforts to increase access to quality care.”

Thirty-five states and U.S. territories applied for the fiscal year 2000 grants, and grantees are required by the grant's end, September 30, 2001, to provide a report to the Secretary detailing their proposals for expanding public-private partnerships to cover all uninsured citizens.

“We expect to receive some interesting and inventive models for covering the uninsured that will be very useful to other states and the nation as a whole,” HRSA administrator Claude Earl Fox, M.D., M.P.H, said.

These state planning grants complement another recently announced HHS grants program – the Community Access Program, also administered by HRSA – that recently awarded about $22 million in grants to 23 communities to help local health providers develop integrated service delivery networks offering uninsured individuals a full range of health care services.

Background information on the State Planning Grants program is available on the Web at <www.hrsa.gov/stateplanning>.

The list of grantees and awards is below:

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Award</th>
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</thead>
<tbody>
<tr>
<td>Arkansas Department of Health Improvement, Little Rock</td>
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</tr>
<tr>
<td>Delaware Health Care Commission, Dover</td>
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</tr>
<tr>
<td>State of Illinois, Springfield</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>Iowa Department of Health, Des Moines</td>
<td>$1,303,731</td>
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<tr>
<td>Kansas Insurance Department, Topeka</td>
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<tr>
<td>Massachusetts Division of Medical Assistance, Boston</td>
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<tr>
<td>Minnesota Department of Health, St. Paul</td>
<td>$1,630,931</td>
</tr>
<tr>
<td>New Hampshire Dept. of Health &amp; Human Svcs, Concord</td>
<td>$1,033,315</td>
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<tr>
<td>Office for Oregon Health Plan Policy and Research, Salem</td>
<td>$1,253,264</td>
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<tr>
<td>Vermont Agency of Human Services, Waterbury</td>
<td>$1,288,892</td>
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<tr>
<td>Wisconsin Dept. of Health &amp; Family Svcs, Madison</td>
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</tr>
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<td><strong>Grand Total:</strong></td>
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Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please visit our Press Release and Fact Sheet search engine at: <http://www.hhs.gov/search/press.html>.
Now that it’s time for another presidential election, it’s also time to revisit the prospects for universal health care. Since the collapse of the Clinton health care reform plan six years ago, no one in either of the major parties has proposed more than incremental steps toward that goal. That remains true during the current campaign.

This approach presents insurmountable problems. One problem is that the limited programs that are supposed to cover targeted populations fail to do so. Take children. There are more children eligible for Medicaid and CHIP who are still uncovered than covered by those programs. The technical difficulties of enrolling target populations cause most of those populations to fall through the cracks.

A second problem is that, as these attempts at incremental reform fail, the prospects for comprehensive health care reform become ever more dismal.

A third problem is that these incremental steps don’t represent steps toward universal health care, for that is a categorically different goal, one that cannot be instituted without mandates. But it is mandates that the political ploy of incrementalism is designed to avoid.

In order to achieve universal health care, it must be our goal. For, regardless of exactly what form it takes, and how we get there, it will require us to design a totally new health system in which all parameters are redesigned, one against which our current system would be seen as dysfunctional.

The Candidates

Only Gore and Nader have addressed universal health insurance. Gore proposes to use the existing Children’s Health Insurance Program enacted in 1997. Since 1997, CHIP has provided insurance, with modest premiums, for about two million children while leaving another eleven million uninsured including about seven million eligible for CHIP. One reason for the poor results to date is that the program relies upon the states to enroll eligible children. The Gore plan would also reduce the uninsured by extending CHIP coverage to the seven million uninsured parents of children who are eligible for either CHIP or Medicaid, but their eligibility would still depend upon the eligibility level set by their state. Gore’s proposal is to provide “universal coverage for all children by 2005,” claiming that it should be seen as an incremental step toward universal health care.

Nader proposes a universal health care system with public funding, administration at the state and local levels, private delivery, and controls against waste, profiteering, and malpractice. Everyone would be covered immediately without preexisting condition(s) exclusions, and the connection to employment would be severed.

Did we really need a World Health Organization Report to tell us how badly we stand on health care issues?

- Ralph Nader, Acceptance Statement

Green Party National Convention, June 25, 2000

In accepting the Green Party nomination, Nader is running on its platform which includes a section on universal health care. It proposes to cover all standard medical procedures, medications, treatment of mental illness, dental care, abortion, and the teaching of holistic, alternative health approaches. It is progressive in redirecting health system priorities. Among the 22 platform planks under Health Care, number 9 reads as follows: “Successful reform of our health care system must start with WELLNESS education; that is, PREVENTATIVE health care. It is each of our responsibilities to tend to our own health through education, diet, nutrition, and exercise.”

In his Acceptance Statement, Nader referred to the WHO Report which ranked the U.S. health system 37th in efficiency (see related article in this issue) and last among all advanced industrial nations, calling that “not only embarrassing but also unacceptable.” The Platform clearly states that “the Green Party considers health care a human right.” To view the entire document, visit <www.gp.org>.

The Costs of Illness

There are various estimates accompanying these proposals about the costs of implementing them, including the tradeoffs that could be realized through greater efficiency. What is not usually offered in proposals merely to improve access, are data on what illness costs our society. In any proposal for universal health care as progressive as Nader’s, consideration of the economic losses due to illness and premature death are a powerful argument for enacting it, and a quantification of just one social justice issue.

There are three components to the cost of illness:

Direct Costs – Total expenditures for public and private health care in the U.S. in 2000 are estimated at $1.3 trillion, or 14 percent of gross domestic product (GDP).

Indirect Costs – Including lost worker output from reduced job performance, missed work due to illness (morbidity), and premature death (mortality) are estimated at $1.7 trillion for 2000.

Intangible Costs – The additional burdens of emotional and physical pain and suffering of patients and family members caused by illness. Although these costs are large, they are difficult to value monetarily.
Improving Services To The Uninsured

Health and Human Services (HHS) Secretary Donna E. Shalala announced today that 23 local networks of health care providers, hospitals, community health centers and local governments have been awarded about $22 million under a new federal program designed to improve access to health care for uninsured Americans.

The Community Access Program (CAP) grants will help grantees in 22 states build integrated health care systems among local partner organizations, all of which are committed to expanding health services to uninsured individuals.

“This grant program’s goal is to assure that more uninsured people receive needed care, that the care received is of higher quality, and that the uninsured are served by providers who participate in accountable health systems,” said Secretary Shalala.

The integrated systems will link all levels of care, including primary health care, mental health services, substance abuse counseling, and dental and pharmacy assistance. Grant amounts vary in size, based on the scope of the project and the size of the service area.

Interest in the competitive CAP grants was strong. The Health Resources and Services Administration (HRSA), an HHS agency, received more than 2,300 requests for application kits and 207 applications for the 23 available grants. Funding requests came in from 44 states, the District of Columbia and Puerto Rico.

“The huge number of applications reflects the importance of the administration’s efforts in trying to bring access to health care to people who need it in communities across the country,” said Secretary Shalala. “This funding is the first installment for what is intended to be a $1 billion initiative over five years and that will ultimately reach approximately 100 communities.”

CAP grant recipients will use the funds to create and expand collaboration among local partners through such strategies as management information systems, referral networks, care coordination and enrollment processes. This year’s grants will bolster efforts at sites that have already begun organizing community-based coalitions to coordinate services to the uninsured.

“The grantees have developed strategies that rely on local resources to build and strengthen integrated health care delivery systems,” said HRSA Administrator Claude Earl Fox, M.D., M.P.H. “These are federal grants, but the design of each grantee’s health care network and its implementation are locally driven.”

All of the grant applications targeted access to health care to uninsured persons. Because racial and ethnic minorities in most communities are more likely than non-minorities to be uninsured, CAP grants support the federal government’s goal – as stated in the Healthy People 2010 document released by the Secretary last January – to eliminate disparities in health status among all groups by 2010.

President Clinton’s budget request for fiscal year 2001 calls for $125 million for CAP, five times the program’s fiscal year 2000 operating budget. If approved, some of that money would be used to fund many of the more than 50 additional applications that were approved in the current grant cycle but not funded due to budget limitations. Fiscal year 2001 money would also be used to fund additional applicants who are approved in a new competition.


Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please visit our Press Release and Fact Sheet search engine at: <http://www.hhs.gov/search/press.html>.

Continued from page 10

Thus the total economic costs of illness are estimated at about $3 trillion annually. These costs represent 31 percent of U.S. GDP.


The goal of the Nader campaign is to get the five percent of the national vote necessary to qualify the Green Party for FEC matching funds based on the campaign’s total fund-raising by November, thereby making the Party a permanent participant in national political discourse. It is to be hoped that he is invited into some of the nationally televised debates in order to help break the social and political gridlock that now blocks any consideration of universal access. He may also succeed in increasing public awareness of how dysfunctional is the structure and the service priorities, how perverse are the incentives for care givers and insurers, and how arbitrary and capricious are the ways in which we ration health care by excluding people in greatest need from it.
Boston APHA
a broad spectrum of health planning sessions
November 12 – 17, 2000
(see special CHPPD session insert)

Have you visited our website today?
<www.ahpanet.org>
Have we missed our last private sector reform opportunity? Last, that is, before imperative factors such as the mass of uninsured, soaring drug costs, significant evidence of avoidable medical errors, and unacceptable health status indicators drive a governmental initiative to control the healthcare system.

Managed care held promise. It’s precepts included evidence-based care, best practices, peer review, appropriate financial incentives—all designed to improve quality and efficiency. In implementation, collaboration succumbed to external control, peer interaction to protocol intervention and efficiency to arbitrage. As a result, managed care has lost favor, managed cost is stumbling, and health care premiums are on the rise.

Cont’d. on page 2

Inside this Issue . . .

- The Shape of Reform
- HRSA Releases State Data
- Change is the Only Constant
- Community: The Fourth Dimension
Will we have another opportunity? If so, what does it look like?

Because of a decade of prosperity, we may have one more opportunity. The economy has provided purchasers some cushion to absorb cost increases and tight employment has lessened their desire to act aggressively regarding health benefits. This economic cushion seems to be disappearing rapidly.

Talk of defined contribution benefit plans and increased cost sharing with employees is increasingly prominent. Medicare and Medicaid are already de facto price control programs indirectly taxing remaining payers.

The reform opportunity may be fleeting. What will we need to accomplish? It will include:

- Recognizing payers’ needs to participate in the process beyond the insurance purchase decision and collaboration among payer, provider and health plan on important structural decisions;
- A customer and patient care focus;
- Automation of routine patient interaction processes;
- Real-time transaction processing with exemplary efficiency, accuracy and management information; and
- Integration around the care process rather than independent components of care systems.

Where is the planning structure to accomplish this? Will it emerge out of recognized necessity? Or will it be a fundamental component of a government initiative?

Welcome to the new Millennium ...
On December 11, 2000, the Health Resources and Services Administration (HRSA) released detailed data on the supply and demand for physicians and nurses and other health care professionals. Commenting on the report, HRSA Administrator, Claude Earl Fox, told BNA that the report's state-specific data gives policymakers a heads-up on the status of the nation's health care workforce and may spur them to take action to retain, retrain, and recruit needed providers.

“Access to quality, affordable health care depends upon the availability of the right mix of well-trained health care professionals to provide services,” Fox said in a press release. “These Profiles will help communities do a better job of monitoring current and future workforce needs and give policymakers a valuable tool to improve planning and funding decisions at the local level.”

The report, State Health Workforce Profiles, provides detailed data on the supply and demand for physicians, nurses, dentists, and some 20 other health care professionals in the 50 states and the District of Columbia, according to HRSA. The report is designed to help state and local officials better monitor current and future health care workforce needs and make local-level funding decisions. The report's findings include an examination of the number of health care workers employed in each state and the growth of health services employment. In California, for instance, there were more than 1 million people employed in the health care sector in 1998, more than 7.3 percent of the state's workers, the report said. However, the state's supply of health care providers is still below the national average of 9 percent.

Registered nurses, licensed practical nurses, and direct care workers, such as nurses' aides and orderlies, constituted the largest group of health services workers in the United States, the report noted.

What's Affecting Supply

Several factors, such as the widespread implementation of managed care and the country's changing demographics, could possibly contribute to any current and future shortfalls in the supply of health care providers, Fox said.

Cont’d. on page 4
Change Is the Only Constant
by Steven E. Feldman, Reviewer
Missouri Certificate of Need Program

They say, if you don’t like the weather in Missouri, wait a minute and it will change. In health planning, change is not only to be expected, but it should be embraced as an opportunity to grow and improve. Therefore, change is the only constant.

The Missouri Health Facilities Review Committee (Committee) and the Certificate of Need (CON) Program Staff are dedicated to the concept of adapting to change in order to improve the review process in Missouri. The mission of the Committee is to achieve the highest level of health for Missourians through cost containment, reasonable access, and public accountability.

We are committed to finding more and better ways to streamline the CON review process, to catch up with the health care industry’s shift from facility-based to service-based health care delivery, and to be more pro-active through effective issue-oriented health planning. It is important that government monitor and manage health resources in a sound business framework. It should also motivate innovative approaches which improve access, restrain costs and increase quality for everyone in our state.

The Committee made a concerted effort in the year 2000 to re-align the CON Program to be more responsive to the needs of Missourians. A special challenge was the development of proposed legislative changes and reforms.

To this end, the Committee hosted a Critical Analysis of CON in Missouri Workshop to discuss and debate issues relating to long term care, hospitals, and ambulatory service settings. The Committee invited elected officials, state department officials, community and business leaders, health care provider associations, and consumer groups to provide input into the discussions. The Committee used the results of these discussions to formulate a plan to update Missouri’s CON Statute.

The result of this collective effort was the drafting of Senate Bill 235, which incorporated the opinions, critical evaluations, and suggestions for changes solicited from the Workshop participants on how to update the CON process to make it responsive to today’s changing health care needs. This bill was introduced in the 2001 legislative session. It would not only streamline the CON review process, but it would change the focus of review from expenditure minimums to a service-based approach. This change of focus would provide for service-based reviews to determine

Cont’d. from page 3

Concerning the implementation of managed care, Fox noted that there has been a “huge shift in how we pay for care in this country with managed care,” which may have affected the perception of the health care industry.

In addition, other market forces, such as Medicare and Medicaid reimbursement levels, may have an impact on the health care workforce, according to Fox.


Cont’d. on page 7
Community: The Fourth Dimension in Public Health
by John Steen, Consultant in Health Planning & Health Policy, Morristown, NJ

In a previous article about the World Health Report 2000 ("With Liberty and Justice for All?" Health Planning TODAY, 3rd Quarter 2000, pp. 3-5; accessible at www.ahpanet.org/policy.html #Liberty), I suggested that the Report is a great advance in the art of health planning on a global scale, and that it directs us to promote social justice by nurturing a shared sense of the intrinsic value we all have as members of one community. In fact, one may see that as the mission and vision of public health in the twenty-first century.

If so, our nation should be using its moral, political, and economic power as a model for the world in the promotion of that vision and the achievement of that mission. Tragically, we are failing to do so, and among the many issues involved in our failure is that of the relation between public health and community. This question is strongly contested in the public health policy community, but it demands some resolution before the promotion of population health is undertaken.

Public Health and Health Promotion

In America, health promotion (or any other kind of promotion) begins with the rights of individuals, but it must not end there. Our concept of the value of human life tells us that human lives should have dignity, integrity, autonomy, and responsibility, where responsibility includes self-discipline and compassion. These are the pre-requisites for our well-being, for without them we will lack the good judgment necessary in realizing and valuing the meaning of our lives.

The most important human values — wellness, quality of life, happiness — are realized through the mediation of our judgment about our life. Clearly then, we are the subjects, not the objects, of these judgments, for we ourselves produce them through our own thinking. We must be asked, not told, about these values.

Respect for these human values requires respect for the right of self-determination on the part of each and every one of us. In practice, that means enabling people to participate in treatment decisions, to engage in public debate and have one’s voice heard on issues, to learn about the health care system and professional practice within it, and in countless other ways to find their own meanings in their own circumstances. With this as our aim, our efforts will be directed toward improving the process of their lives, and will recognize the community as a vital resource in providing that process.
The National Health Planning and Resource Development Act of 1974 (PL.93-641), that launched modern community health planning, embodied the sort of community process that could develop consensus for public health programs.

It was the failure to appreciate the need for public consensus that, among other factors, doomed the Clinton Health Plan to failure. Reform of so monumental a subject, human value, and industry as health must be undertaken through the cultivation of public opinion in which understandings are reached, and values shared. We must be offered the opportunity to come to terms with issues of value that may separate us in order to reach common judgments and a consensus on how to proceed.

Ultimately, we need to develop a new understanding of how we perceive health. (Is it a right?) Instead, the Clintons offered us a Black Box, and with it, the call to trust them, a call which was antithetical to the only means by which their aims might have been achieved. The quality of governance has great bearing on the social capital of communities, and the political-social interaction works both ways. Poor governance elicits the community’s distrust of government.

The lesson for public health is that some public health strategies have the unintended negative consequence of preempting debate, and through it, the formation of public opinion and the growth of social capital. Community health educators should promote public process in the interest of empowering communities to better see themselves, exercise better judgment about what really matters to them, and seek harmony in the values that matter. Community health education through dialogue should be seen as the heart of health promotion, and the responsibility of any health plan that countenances a mission of building healthier communities.

The new National Public Health Performance Standards call upon public health to institutionalize a commitment to community processes that evaluate quality of life, prioritize problems and solutions, and do so in consonance with community themes, all in the interest of expanding the social capital of communities. Done properly, community empowerment will replace short-term community engagement, and accountability will replace paternalism.

**Public Health and Social Capital**

The aim of public health is not to make people healthy, but to assure the conditions in which people can be healthy. The well-being of a population is the collective judgment of its members about their quality of life. Their quality of life is largely determined by the quality of their political, social, economic, and other institutions. There is growing evidence, through recent studies, that social capital is to communities as wellness is to individuals. And social capital cannot be given to a community like a vaccination. It must be grown from within.

What I am suggesting by the title of this article is that public health must acknowledge communities to be the primary subjects of its practice. The three dimensions of public health – the familiar triad of agent, host, environment – represent a dynamic that exists within the fourth dimension of community. Community determines the effects, quantitatively and qualitatively, of that dynamic. And people are themselves agents in the cause of pursuing their own wellness, and not to be manipulated as mere hosts.

This is what I see to be health planning’s signal contribution to public health: **Giving voice to community as a means toward improving not only health care,**

*Cont’d. on page 7*
community rather than cost-based reviews after a proposed project’s cost exceeded some arbitrarily set expenditure minimum.

It should be remembered that the words of a dying company are, “But we’ve ALWAYS done it this way!” In addition, I’m sure that the last buggy whip company in America made some of the finest buggy whips before they went out of business. Also, the stage coach business died because they erroneously thought they were in the stage coach business . . . they weren’t . . . they were in the transportation business, but they didn’t realize it.

In other words, it is vitally important to be able to adapt to changes in order to survive. If CON is to survive in Missouri, it must change from a purely re-active regulatory function to a more pro-active planning function. It is by adapting to change that the Committee will be able to complete its mission.

Cont’d. from page 6

but all the other upstream conditions for our quality of life. Our aim as health planners should be to elicit a stronger sense of community, and through it, a stronger sense of belonging, cohesiveness, and trust among community members. Then we can see the social solidarity of a community as its immune system, and see that we all have the same vital interest in supporting it for our common benefit.

Cont’d. from page 4

Articles for the 2001, first quarter journal are due on March 1. The articles should be short — no more than a single page of text.

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