

Review & Commentary on Health Policy Issues from a Rural Perspective - October 1<sup>st</sup>, 2001

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## Not Rural To Urban But Rural-Urban To Fringe

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From the National Center for Health Statistics' *Health, United States, 2001 With Urban and Rural Health Chartbook*; available at <www.cdc.gov/nchs>. In each edition of *Health, United States*, a chartbook focuses on a major health topic. This year *the Urban and Rural Health Chartbook* describes the health of people living in urban and rural communities (classified into five urbanization levels, three for metropolitan and two for nonmetropolitan counties.) Urban and rural communities have different health priorities that are related to differences in demographics, health behavior, geographic isolation, and access to health care:

“Improving health behaviors to reduce the risk of disease and disability poses distinct challenges for central counties of large metro areas, with their ethnically diverse and large economically disadvantaged populations; equally difficult but different challenges confront the most rural counties with more dispersed and older populations.”

### Urban-Rural Health Risk Factors

“Nationally, **adolescents** living in the most rural counties are the most likely to **smoke** and those living in central counties of large metro areas are the least likely to smoke. In 1999 for the United States as a whole, 19 percent of adolescents in the most rural counties smoked compared with 11 percent in central counties.”

“Nationally, **adults** living in the most rural counties are most likely to **smoke** and those living in large metro (central and fringe) counties are least likely to smoke (27 compared with 20 percent of women and 31 compared with 25 percent of men, in 1997–98).”

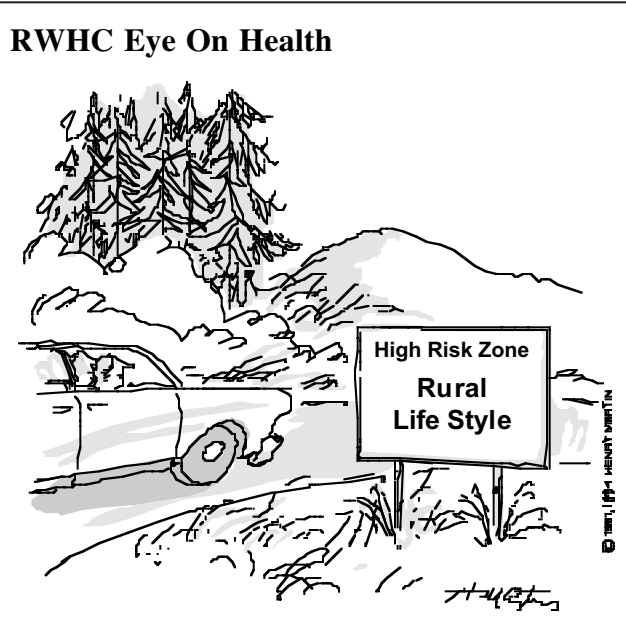
“Self-reported **obesity** varies more by urbanization level for women than for men. Nationally, women living in fringe counties of large metro areas have the lowest prevalence of obesity and women living in the most rural counties have the highest (16 compared with 23 percent in 1997–98). Self-reported obesity among men ranges from 18 percent in central counties of large metro areas to 22 percent in the most rural counties.”

### Urban-Rural Mortality

“For the United States as a whole and within each region, **infant** mortality rates are lowest in fringe counties of large metro areas. In the Northeast and Midwest, central counties of large metro areas had the highest

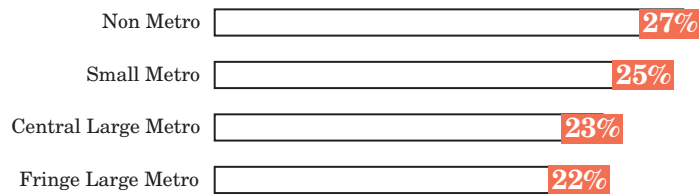
infant mortality rates in 1996–98 (45 percent higher than in fringe counties), while in the South and West, nonmetro counties had the highest rates (24 and 30 percent higher than in fringe counties).”

“For the United States as a whole, death rates for **children and young adults** (ages 1–24 years) are lowest in fringe counties of large metro areas and highest in the most rural counties. In all regions except the Northeast, 1996–98 death rates in the most rural counties were over 50 percent higher than rates in fringe counties. In the Northeast and for males in the Midwest, death rates in central counties are as high as those in the most rural counties.”



“Nationally and within each region, death rates for **working-age adults** (age 25–64 years) are lowest in fringe counties of large metro areas. In the Northeast and Midwest, 1996–98 death rates were highest in central counties of large metro areas (34–53 percent higher than in fringe counties). In the South, death rates were highest in nonmetro counties (31–44 percent higher than in fringe counties). Nationally, death rates among **seniors** (age 65 years and over) are lower in large metro (central and fringe) counties than in nonmetro counties.”

### Cigarette Smoking Among Persons 18 Years Of Age By Urbanization Level, 1997-98



Data: *Health In US, 2001*  
Graph: RWHC, 9/01

“For adults 20 years and over, urbanization patterns in **ischemic heart disease** (IHD) death rates differ by region. In the South, 1996–98 IHD death rates were lowest in fringe counties of large metro areas and over 20 percent higher in the most rural counties. In the Northeast and West, IHD death rates were highest in central counties of large metro areas.”

“For men 20 years and over, death rates for **chronic obstructive pulmonary diseases** (COPD) are lowest in large metro (central and fringe) counties and highest in nonmetro counties. For the nation, COPD rates among men were 30 percent higher in nonmetro counties than in large metro counties in 1996–98.”

“Nationally and within each region, death rates from **unintentional injuries** increase markedly as counties become less urban (nationally, over 80 percent higher in the most rural counties than in fringe counties of large metro areas in 1996–98). Death rates for **motor vehicle traffic-related injuries** in the most rural counties are over twice as high as the rates in cen-

tral counties of large metro areas. Nationally and within each region, **suicide** rates for males 15 years and over are lowest in large metro (central and fringe) counties and increase steadily as counties become less urban.”

### Other Urban-Rural Health Measures

“The **birth rates for adolescents** 15–19 years of age are lowest in fringe counties of large metro areas. In the Northeast and Midwest, adolescent birth rates are substantially higher in central counties of large metro areas than in other urbanization levels. In the South and West, adolescent birth rates in small metro and nonmetro counties were similar to those in central counties (all more than 30 percent higher than rates in fringe counties).”

“For the United States as a whole, **limitation in activity due to chronic health conditions** among adults is more common in nonmetro counties than in large metro counties.”

“For the United States, **total tooth loss** among seniors increases as urbanization declines. In 1997–98, almost one-half of lower income seniors living in nonmetro counties had lost all their natural teeth.”

### Urban-Rural Health Care Access and Use

“A community’s health depends not only on the socio-demographic characteristics and risk factors of its residents, but also on their access to and use of health care services. Factors affecting access include health insurance coverage as well as provider supply.”

“**Lack of health insurance** among nonelderly Americans is least common in fringe counties of large metro areas and most common in central counties and in the most rural counties. In 1997–98 lower income nonelderly persons were over three times as likely to be uninsured as higher income nonelderly

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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## Seven Keys To Aging Well

From Dr. George Vaillant, Director of the Study of Adult Development, Harvard Medical School as reported in *Parade Magazine*, 9/16/01:

Not Smoking, Or Quitting Early: “Those who quit the habit before 50 were, at 70, as healthy as those who had never smoked. And heavy smoking was 10 times more prevalent among the ‘Prematurely Dead’ than among the ‘Happy-Well.’ ‘Smoking,’ said Vaillant, ‘is probably the most significant factor in terms of health.’ ”

The Ability To Take Life’s Ups And Downs In Stride: “If you can make lemonade out of lemons, then you have an adaptive coping style, also known as ‘mature defenses.’ Mature defenses don’t actually ensure good health at an older age. But a person will suffer less from life’s real problems if he or she has the ability to roll with the punches.”

Absence Of Alcohol Abuse: “ ‘Abusing alcohol destroys both your physical and mental health,’ Vaillant noted. (He added that a partner’s alcoholism can destroy a marriage, which also may have an impact on how one ages.)”

Healthy Weight: “Obesity is a risk factor for poor health in later life.”

A Solid Marriage: “This is important for both physical and psychological health. ‘Happy-Well’ people were six times more likely to be in good marriages than were the ‘Sad-Sick.’ ”

Physical Activity: “The study specified that the ‘Happy-Well’ usually did ‘some exercise.’ The benefits of fitness also extended to mental health.”

Years Of Education: “Vaillant speculated that people to whom ‘self-care and perseverance’ are important are also more likely to continue their educations. These individuals, he surmised, are able to take the long view. ‘People seek education because they believe it is possible to control the course of their lives,’ he said.”

***“People who had four or more of these seven factors at age 50 were one-third less likely to be dead by 80. People who had three or fewer of these factors at 50—even though they were in good physical shape—were three times as likely to die during the following 30 years.”***

persons at all urbanization levels. About one-third of lower income residents of central and nonmetro counties were uninsured in 1997–98.”

“The urbanization pattern for **physician supply** depends on physician specialty. In 1998 the supply of family and general practice physicians rose slightly as urbanization decreases. The supply of all other types of physicians decreased markedly as urbanization decreased, nationally and in all regions.”

“Nationally and in each region, **dentist supply** decreases markedly as urbanization decreases. The urbanization pattern for **dental care use** is similar to that for dentist supply. In 1997–98 for the United States as a whole, only 57 percent of adults (ages 18–64 years) in the most rural counties reported having a **dental visit** within the past year compared with 71 percent in fringe counties of large metro areas.”

“**Inpatient hospital discharge rates** among adults (ages 18–64 years) are higher in nonmetro than in metro counties. Higher hospital use in nonmetro areas may result in part from delays in seeking care for conditions that could have been treated in ambulatory settings if detected earlier.”

“Admission rates to **substance abuse treatment** programs vary by primary substance and urbanization level of the county where the program is located. Nationally, alcohol treatment admission rates are higher in small metro and nonmetro counties with a city of 10,000 than in counties at other urbanization levels. Admission rates for opiates and cocaine tend to decrease as urbanization decreases.”

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## Secretary Thompson True To His Rural Roots

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The Secretary of the U.S. Department of Health and Human Services (DHHS) wants to know how his department serves the country’s rural residents and he’s turned to the Federal Office of Rural Health Policy (ORHP) to get the answers. Tommy G. Thompson has asked Dr. Marcia Brand, Director of ORHP, to lead an internal review of all DHHS programs.

“As former governors of states with large rural populations, President Bush and I know how important it is for people outside urban centers to have access to quality health care and social services. We have carried that understanding to the White House and HHS,” Secretary Thompson said to the Joint International Summit on Rural and Community Development.

The Task Force will report back to the Secretary within three months and will be the first comprehensive assessment of how HHS serves rural America. The idea for the task force emerged from Secretary Thompson's visit to ORHP in May as part of a larger tour of HRSA.

"The Secretary made it clear in that meeting that he wanted to do something to improve health services for rural communities," said Dr. Brand. "The challenge is figuring out what to do. The Task Force is the first key step in that direction."

There are 54 million Americans who live in rural areas. Health care can represent up to 20 percent of a community's employment and income. In some lower income communities, Federal support may account for as much as 50 percent of the income in the community. Medical care and a strong social services network are also important factors for employers who might consider moving to or expanding into rural communities.

The Federal Office of Rural Health Policy serves as a natural coordinating body for this activity. The Congress created ORHP in 1987 to act as a voice for rural within HHS. Since its inception, ORHP has worked to provide a rural perspective across HHS.

"The Task Force will reach across all 12 divisions in HHS and will work to assess how we can do a better job of expanding and improving the provision of health care and social services in rural America."

"The Task Force will consider any and all ideas," Secretary Thompson said. "However, it is imperative as we begin this effort that we remember that rural Wisconsin is different than rural Maine, rural California, or rural Georgia. In health care, rural hospitals and their needs will differ, too, even as the underlying challenges remain the same. In social services, individuals and families need supportive services, adult and child-care services, and help securing child support without regard to where they live or the size of their community."

The initial work of the Task Force will be internal as the various operating divisions within HHS join to-

gether to begin a rural self-assessment. The idea is to identify current barriers to serving rural individuals and families. Each agency will be asked to find ways to strengthen existing programs and services.

**Agency for Healthcare Research and Policy (AHRQ):** Fund research and dissemination of best practices relevant to the scale and context of typical rural facilities. The federal investment in health care research and quality should reflect the diversity of settings in which patients are seen, not just those most convenient for researchers.

**AHRQ:** Fund research and dissemination of best practices relevant to local leaders seeking to create organizational and systemic change. Quality improvement is more than just the medical science about desired outcomes but is also dependent on and informed by the behavioral and political sciences.

**Critical Access Hospitals (CAHs)—Emergency Expansion 15 Bed Limit:** Be explicit that in the case of an epidemic or an emergency, the 15 bed limit can be exceeded without penalty. The role of the hospital is to

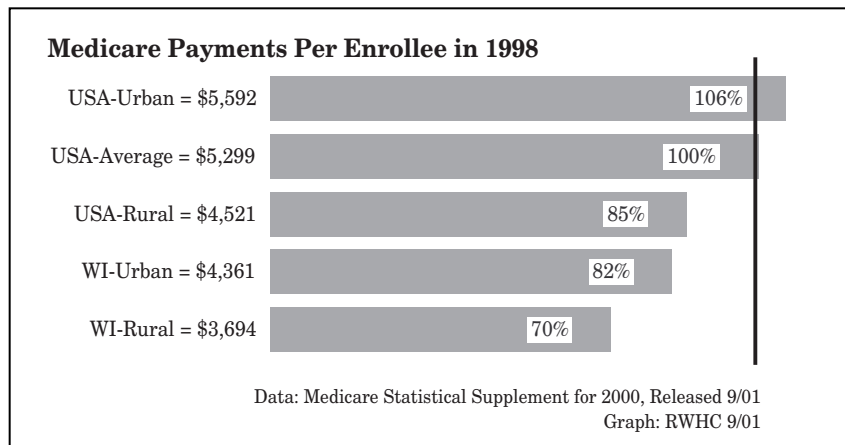
serve the local community in unusual situations, even if it means violating the 15 bed ceiling.

**CAH—Flex Grants:** Work with Congress to assure the continuation of the Flexibility Program grant. These focused investments in state offices of rural health and the development

of local critical access hospitals have become a key component of the states' rural health infrastructure.

**CAH—Long-Term Care:** Work with Congress to assure that CAH based home health and skilled nursing facilities should be reimbursed based on reasonable costs. Home health services and skilled nursing facilities are critical and natural components of critical access hospitals.

**Capital—Mandates:** Work with Congress to assure transition funding is made available for the capital cost required of rural hospitals to implement need mandates such as HIPAA and new Patient Safety requirements. A convergence of demands for major unanticipated regulatory driven capital investments comes at the same time when Hill-Burton era facilities face replacement of their core facilities.



**Community & Economic Development:** DHHS proposals which affect local health care need to explicitly consider the impact on the rest of the rural community and economy. "Every two jobs created (or lost) in the Sauk County health care industry will cause the number of jobs in other industries to increase (or decrease) by one job." From the most recent study supported by RWHC, *The Economic Value of the Health Care*.

**CRNA:** Eliminate the limit on the number of procedures eligible for a pass through of CRNA service costs in rural hospitals with less than 100 beds. The current eligibility limit of 500 procedures is artificial for the typical rural hospitals and is leading to a substantial underpayment in many facilities of the actual cost of providing the service.

**Federal Office Of Rural Health Policy:** Further enhance the ombudsman role of both the National Advisory Committee on Rural Health and the Federal Office of Rural Health Policy within DHHS. The expertise inherent in both the NACRH and the FORHP has been historically underutilized by DHHS as a whole.

**Medicare Conditions Of Participation:** Integrate the federal regulations impacting diversified rural hospitals with multiple provider types. Wisconsin's pioneering "rural medical center" concept—a single license for rural provider campuses providing multiple services (e.g., hospital, SNF, home health).

**Medicare Cost Report:** Simplify the cost report. A national task force of external and DHHS experts should be convened to report out specific recommendations by a time certain in 2002. The work already complete by an existing AHA task force on this issue should facilitate an expedited review. The cost report should be limiting to the information actually needed by PPS or if not a PPS provider, the information needed by the applicable payment system.

**Medicare Payment Advisory Commission (MedPAC):** DHHS should encourage that the statutory requirement for rural representation on MedPAC proportionate to the rural population be met or exceeded. In particular representation of rural providers is sorely needed. The rural voice must be part of all MedPAC deliberation; when only one or two members represent a rural perspective, it is very difficult for even the most skilled advocate to be effective.

**Medicare Peer Review Organizations (PROs):** Require PROs to make consultation available to rural providers. The current 6<sup>th</sup> Scope Of Work (SOW) creates incentives for PROs to NOT work with rural providers but to focus their technical assistance on large volume providers.

**Medicare Prospective Payment System (PPS):** Work with Congress to assure that the Prospective Payment System adopt as an explicit goal that the AVERAGE Medicare Operating Margin for rural hospitals should be the same as the AVERAGE for urban hospitals. Support MEDPAC's current sensitivity to rural vs. urban margins and encourage them to drill even deeper into rural issues. To do otherwise is to perpetuate an unearned stereotype that rural boards and rural administrators are less able. The public policy basis for PPS has always been to hold hospitals harmless for costs outside of their control to influence; the classic example is the adjustment for higher than average case mix or area wage levels. The concept needs to be more uniformly applied to rural hospitals which face high fixed costs and low volumes.

**Wisconsin Farm Health Summit  
November 2<sup>nd</sup> in Madison**

Hosted by the three Wisconsin Secretaries  
of  
Commerce, Health and Agriculture  
Registration Brochure at [www.rwhc.com](http://www.rwhc.com)

**Medicare PPS—Hospital Wage Index:** Fast track implementation of the occupational mix adjustment so that it is in effect for FY 2003 or 2004. There is an anti-rural bias in the wage index due to a lack of an occupational mix adjustment which represents an inequitable underpayment of numerous rural facilities; its correction is long overdue. The statutory requirement is for implementation no later than October 1<sup>st</sup>, 2004; but the occupational mix adjustment can and should be implemented earlier.

**Medicare Rural Hospital Cost Based Reimbursement:** Support legislation to allow hospitals not eligible for CAH but under 50 beds the option of cost based reimbursement. There is a significant number of hospitals with volumes too high to be eligible for CAH but too low to survive under PPS.

**Research & Analytic Studies:** Consistently disaggregate data so that the rural context is evident. Rural realities are constantly lost through a failure to collect or present data that describes local conditions.

**Telehealth:** Balance funding of hub and spoke models with funding for intra-rural networking alternatives. The early involvement of DHHS in telehealth was disproportionately effected by the expertise and interest of specialty medical centers.

**Workforce—Academic Grants:** All workforce related grants to educational and training institutions must be required to demonstrate the active involvement and concurrence by effected providers. Creating an ongoing dialogue and collaboration between “academe” and rural providers must be a fundamental goal of any workforce initiative; historically and to date, this has been a significant barrier.

**Workforce—Rural Training Sites:** Reimburse the cost to rural providers of hosting clinical rotations, including the incentives necessary to attract rural based educators and clinical practitioners. Addressing the rural workforce shortage requires maintaining and expanding rural training sites. As rural operating margins continue to be severely challenged, fewer rural providers are able to subsidize education and training clinical rotations. The bias of GME being primarily for teaching hospitals must be ended.

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## More Health Insurance Hikes Predicted

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From “Experts Predict Slowing Economy Will Lead To Hike In Health Insurance Rates” by Jean Fischer, *Raleigh News & Observer*, 8/21/01:

“Health insurance companies are delivering a killer shock for employers and their workers: the biggest rate increases in more than a decade. With layoffs and unemployment on the rise, employers will be more willing to shift costs to employees. And fear for job security is spreading, leaving workers with little choice but to accept the higher premiums.”

“Analysts who track the costs of health benefits are predicting average rates will jump by as much as 20 percent nationally, a figure that harks back to the 1980s and the days of skyrocketing medical costs that preceded the introduction of cost-saving HMOs. Adding to the hurt: Next year's expected increase comes after rate increases in the low teens for 2001 contracts.”

“Rates have been rising for about the last three years, but we were enjoying a robust economy and a robust stock market, and employers were more willing to absorb the cost,’ said Steve Graybill of the benefits firm William M. Mercer in Charlotte, N.C. ‘This year, everyone is feeling squeezed, and I think we’re going to see employers passing more costs on than ever before.’ ”

“Rates are increasing rapidly because medical costs are also soaring, health insurers say. Prescription

drugs cost more. Medical office visits are up. And those trends are likely to continue, thanks to health plans that no longer require enrollees to get referrals for specialty care, industry representatives say.”

“ ‘The industry has taken a turn in giving people what they want,’ said Susanne Powell of Blue Cross Blue Shield of North Carolina. ‘They want more choice, they want more flexibility, they want plans that are easier to use. That does not come without some cost.’ ”

“Some industry watchers say the sharp increases may also be the result of a natural market shakeout. In the 1980s and early 1990s, health insurers entered the national and local markets with low rates to attract members. Competition among plans kept a lid on premiums through the middle 1990s.”

“ ‘Some plans really under priced the market and found they couldn't sustain it, and then we started to see consolidation,’ Graybill said. ‘What's happened is that the strong got stronger and the weak got weaker.’ ”

“Rates began to creep up in 1998 and, last year, rate increases hit double digits for the first time in more than a decade.”

“ ‘People were sort of lulled through the 1990s because of low rates,’ said Larry Levitt of the Kaiser Family Foundation in California, which closely tracks shifts in health insurance coverage.”

“ ‘The alarm clock has gone off, and there still aren't any obvious solutions. Employers used to turn to managed care to control costs; now there's no relief anywhere,’ Levitt said.”

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## Wisconsin Needs To Plan Its Future Workforce

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From unpublished comments by Diane Peters, Vice President, Workforce Development, at the Wisconsin Health & Hospital Association, 9/01:

“Health Services is one of the top three industries in Wisconsin and is expected to account for one in three new jobs in Wisconsin between 1998 and 2008.”

“There is no dispute that the adequacy of the existing and projected health care workforce is reaching crisis proportions at both the state and national level. If not addressed, there will be a collision resulting from the decreased supply and the increasing demand for health care services. This will have severe implica-



tions for Wisconsin's healthcare industry and the healthcare services available within the state."

"Although the problem is universally recognized, state and national data is woefully lacking. The lack of meaningful data on supply and demand, employment recruitment, retention and/or pipeline information makes it difficult for policy makers to precisely identify the magnitude and the specifics of imbalances between the supply and demand for healthcare workforce."

"Timely and comprehensive health care workforce data for Wisconsin is critical to be able to adequately define the problem and indispensable for the purposes of devising, implementing and measuring effective policy designed to address the crisis. While many agencies in Wisconsin are collecting data, their respective efforts have been unfocused, fragmented and uncoordinated. Information that incorporates the multiple aspects of the workforce including recruitment, retention, age, education, licensing, credentialing, supply and demand are vital if Wisconsin is to make sound policy decisions regarding what is a critical issue for Wisconsin."

"The Department of Workforce Development (DWD) needs to assume the leadership role in compiling workforce data necessary to identify, dissect and resolve the problem. DWD is the key state agency capable of leading this initiative and coordinating the collection, analysis and dissemination of vital data and information. DWD needs to take the lead in development of a comprehensive plan to address the problem."

"DWD needs to establish a special healthcare workforce initiative with a focus of development of a healthcare workforce that of the size and caliber to meet the health care needs of the citizens of the state."

"DWD needs to take the lead in collaborating with other state agencies (Regulation and Licensing, Bureau of Health Information, Department of Health and Family Services, Wisconsin Technical College and University Systems), and with the health care industry and professional associations to identify data needs, develop collection tools and methods and then analyze the data collected."

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## The Role Of Quality Report Cards?

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From "Accountability And Quality Improvement: The Role Of Report Cards," an editorial by Professor M N Marshall at the University of Manchester in *Quality in Health Care* 2001;10: 67-68:

"Ensuring accountability and improving quality are two of the most significant challenges facing health systems around the world. The public release of comparative standardized information on quality in the form of 'report cards' represents one suggested solution to these complex problems. Report cards are not new—Florence Nightingale produced a report comparing the mortality rates of London teaching hospitals in 1863—but nevertheless they have been embraced with great enthusiasm in many developed countries in recent years."

"Given this enthusiasm, it is perhaps surprising that we know so little about the uses, benefits, and risks of publicizing comparative information. It may seem self-evident that the general public should be the primary audience for the 'public' release of comparative information. Not so, it would appear. Even in the consumer orientated USA where users have expressed a desire for the information in principle, in practice they do not appear to search for, understand, trust, or make use of the data. This must have come as a shock to the proponents of report cards who expected consumers to respond to the information in a rational way, weighing up the costs and benefits, making a judgement about which providers were best, and driving low quality providers out of the competitive market."

"Researchers and policy makers have attempted to explain this apparent paradox in terms of deficiencies in the content, presentation, or dissemination of the data or in terms of the lack of real choice for many US citizens. In doing so they may have missed the point. The apparent disconnection between the public's demand for information and their use of report cards is perhaps not as paradoxical as it first appears. It is possible that service users are simply saying that they want the information to be available and that they are dissatisfied with what they perceive as the veil of secrecy and professional protectionism currently seen in health care. It is, of course, possible that better data or well informed and empowered consumers will be more willing to use report cards in the future, but it is probable that the impact of report cards on consumer behavior will always be marginal."

"Perhaps the rational choice model of decision making, so admired by economists, is an inappropriate way of explaining the public's choice of healthcare providers. Is it possible that the public simply does not want to behave in a consumerist way in all aspects of modern life? Socio-behavioral models of decision making which recognize the complex input of beliefs, experiences, enabling factors, and the unique self-perception of problems are more useful in explaining the public response to report cards. In an attempt to understand the role of report cards it might then be more

productive to re-focus attention on the mechanisms of lay decision making, the merits of expert held knowledge, and the role of advocates in making use of complex comparative information.”

“Those who are disappointed by the apparent disinterest shown by consumers may gain solace from the paper on public disclosure in this issue. Davies suggests that US hospitals do make use of comparative information and that the public release of the data acts as a catalyst by reminding, refocusing, or shaming the organizations into giving priority to quality improvement. Again, the author suggests that the data are not used in an entirely rational way. Respondents tended to use the report cards to confirm their views about the performance of their own and other organizations, views which were based primarily on informal contacts and personal experiences. If the ‘hard’ data did not support their prejudice, then they were more likely to judge the data to be incorrect than to accept that their own views might be wrong.”

“Nevertheless, the report cards served an important purpose by stimulating the organizations to look beyond the published data and encouraging them to develop and improve their own internal data systems. This suggests that the data contained in report cards have to be accurate enough to engage the attention of those whose responsibility it is to take action, but does

not have to be perfect. If correct, this has important policy implications. The New York Cardiac Surgery Report System, for example, disseminated sophisticated risk adjusted data which enabled reasonably valid and reliable judgements to be drawn about the relative performance of individual cardiac surgeons and hospitals in the state of New York. Such data are extremely costly and time consuming to produce. This might be a necessary expense if the aim of the data is to make proscriptive judgements about fitness to practice, but may not be required if the aim of the report cards is to encourage engagement with the quality improvement process.”

“The introduction of report cards in the USA is not a shining example of implementing a radical and innovative health policy. The enthusiasm for the public reporting of performance is understandable; it must be right to provide information in an open and democratic society and it must be better for all stakeholders to be informed than to be kept in the dark. However, the initial expectations of report cards in the USA seem in retrospect to be naïve. There can be little doubt that comparative information about quality of care will be freely available in most developed countries within the next decade. Those who are responsible for introducing report cards and those who wish to make use of them would do well to examine the rapidly expanding literature in this field.”

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