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Back to the Future: Partnerships and Coordination for Community Health

Summary

In the current tumultuous health care scene, competitive health plans and capitated delivery systems are becoming the driving forces in the health care marketplace. Although these plans may be successful in containing costs, their competitive nature prevents them from providing leadership in comprehensive, coordinated initiatives to benefit the entire community. In contrast, executives and trustees at the frontiers of health services management are reaching beyond the current scene toward a vision of community care networks. They are taking incremental steps to coordinate care of patients, enrolled populations, and communities—both within and among independent organizations in the public, for-profit, and not-for-profit sectors. As they bring increasing competence in coordination to bear on complex problems of long standing, a health care system that actually delivers more for less to all is a real possibility. My historical perspective, dating back to the studies of the Committee on the Costs of Medical Care (1928–1932), convinces me that community coordination is the missing element in moving from our current fragmented health system to an ever more effective system. This article suggests that the CCMC was on the right track in recommending that every community have an agency to exercise coordination functions, relying on the power of knowledge and persuasion rather than control. Presented here are details of how to organize and manage such an entity as well as a discussion of the nature of the leadership and the incentives required to overcome obstacles to this essential approach.

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THE BEST-KEPT PROFESSIONAL SECRET

Everyone knowledgeable about health care systems knows that the United States spends a higher proportion of its gross domestic product on health care than any other country, and that its health care outcomes do not measure up to those of many other industrialized democracies. The general public is beginning to realize that this is the case. Nevertheless, every single reform proposal that has surfaced in Congress projects ever greater expenditures.

Despite a strong commitment to the notion of universal entitlement, the public appears to be skeptical of any reform that diverts more and more scarce resources into the health care system. The public suspects—and rightly so—that once the government makes a commitment to universal entitlement that can only be delivered by the fragmented health care system, health care expenditures will rise at an even faster rate than anyone yet has anticipated. As a result, health care reform at the national level is stalemated. Humane access to the nation's ample health care resources continues to be beyond the reach of millions of people without adequate insurance or knowledge of how to "work" the system.

What the general public does not yet know is that almost all professional executives in the health care field will admit that, with strong community partnerships and coordination to reduce the fragmentation that characterizes the health care field, this nation can theoretically have better health care for all, and without any increase in expenditures at all. Many health care executives even agree privately that health status could be improved as health care expenditures are reduced substantially. How much longer can the professional managers hide behind the naiveté of the health policy professionals and keep this secret from the public?

The fact that it is possible to reduce expenditures through stepped-up coordination and achieve better results must now be shared with the public. But the general public is not likely to get behind the idea until convinced that those responsible for governing and managing the elements of a more coordinated health system actually know what to do. In the absence of that level of understanding, it is not surprising that those concerned with containing health care costs concentrate on marketplace forces or government regulation to do the job, with little or no emphasis on the potential of community and professional initiatives.

Isn't it time for professional health care managers to provide leadership by speaking up on what they know to be true: that with strong community support, patience, and visionary governance

they can overcome the fragmentation of the health care system and guarantee access to decent health care for everyone at much less cost? Even though at this time professional health managers do not have much public visibility or credibility, is there another group who could make this point and be taken seriously? After all, the professional managers are the ones who do the work, and what better way for the health care management profession to gain the kind of public credibility that any profession should treasure?

Historical Perspective

Without historical perspective, the notion of communities getting better health care with fewer resources seems too absurd to be taken seriously. Those of us who remember World War II see the situation differently. Half the physicians and half the nurses left their communities along with the healthiest segment of the population, prices and wages were frozen, and capital investment in the health field was limited to temporary wooden construction in war-affected areas.

With severely reduced human and economic resources and a less healthy population, what happened to the health system and to community health indices? In every community throughout the land, community leadership met the challenge—hospital trustees, caregivers, executives, business and union leaders, government officials, volunteer organizations, "just plain folks"—and the health of the communities was maintained, and in most situations, it actually improved. Of course, those were simpler times and the health care system was less complex than today; then the threat of madmen trying to take over the world made it easier to stimulate innovative community action. Times are different now; most Americans' sense of community has weakened. As a result, community coordination and partnerships must also be different. However, the basic benefits of coordination are the same.

Historical perspective demonstrates that health care managers cannot, by themselves, initiate and carry out the reforms that would lead to a more coordinated and more effective health care system in their communities. Strong leadership and commitment is required from many other forces in the community—and beyond. But this type of community leadership is not likely to emerge in the current health scene unless there is evidence that at least some of the managers are ready and able to do the right thing. In that sense, the leadership role of professional health care managers is crucial.

If the managers are not ready to be out front on this issue, they are well advised to prepare for the inevitable drastic reduction in health care resources that will be imposed one way or another, sooner rather than later, from outside the community. Without preparation, there will be much pain; with preparation, there will be much to gain. I do not think there is too much time left to consider the options. Managed competition will not be able to do the job by itself. Without community focus, cost containment becomes an end in itself, and there will be much suffering as managers are forced to concentrate more and more on staying afloat instead of on solving health problems.

We have learned that reform is quite different from revolution, particularly in developed countries with complex political processes as in the United States. Whereas revolutions usually represent a sharp break from the past, successful reform almost always reflects acceleration of trends and developments that have been quietly underway for many years. This is why historical perspective can be extremely valuable in formulating realistic reform proposals and in assessing the value of the myriad proposals that are always circulating during reform eras. Without historical perspective on the nature of the change processes at work in the health care field, almost all efforts to accelerate the pace of change are likely to be demonstrably inefficient, if not total disasters.

In the current period, many who are formulating reform initiatives at the national level know little of the successes and failures of past reform efforts, but bring powerful analytical tools to bear from disciplines largely untapped in earlier reform efforts in this field. These include economic analysis of complex markets, as well as economic, sociological, and political analysis of organizational development ranging from the individual firm to complex international enterprises and entire nations. We are fortunate to be in a position to benefit from the marriage of today's powerful analytical tools to the lessons of yesterday's reform proposals. The recommendations detailed in the following section provide a frame of reference for the reform proposals of today.

THE CCMC RECOMMENDATIONS

Comprehensive approaches to health care reform in the United States can be dated from the publication in 1932 of *Medical Care for the American People*, the final report of the Committee on Costs of Medical Care (CCMC) (see also Weeks and Berman 1985). This amazing document provides both the factual and the

conceptual basis for almost every health care reform initiative throughout the nation for the four decades following its publication. Interest in the CCMC reform proposals tended to fade during the seventies, as interest began to focus on marketplace incentives and other efforts to exploit mercenary energy and discipline in the public interest. Although the notion of major initiatives from investor-owned profit-driven hospitals, hospital systems, health maintenance organizations (HMOs), and health plans was anathema to all of the CCMC members, it can be incorporated into their framework, as will be shown in what follows.

While major health care reform appears to be stalled at the national legislative level, there is much to learn from the 1932 CCMC volume with respect to how to analyze the health care system, how to develop an appropriate framework for formulating reform proposals, and how to involve diverse elements in a process that was able to produce alternative reform recommendations of great power. The 63-year-old recommendations seem at least as relevant as many of the proposals currently under discussion. The five brief CCMC recommendations are shown in Figure 1.

In summary, looking ahead 25 to 30 years, the CCMC recommended that health services should be provided by organized groups of professionals, preferably hospital-related, with the conversion of hospitals to comprehensive community medical centers, networked within regions; that public health services be greatly expanded and clearly defined to include community-focused activity of nongovernmental entities; that costs should be met by group payment managed by the health service networks themselves; that professional education should be greatly strengthened; and that services should be coordinated at the community and state levels.

Each of the CCMC recommendations can be analyzed and updated, reflecting developments since publication. That work is in progress and provides a great deal of insight into how to make reform work. As an introduction to this effort, the remainder of this article will be devoted to only one aspect of one of the CCMC recommendations that has never been fully implemented and is receiving little attention at this time—*community coordination for better health and more effective health services.*

Broadly speaking, three of the five CCMC recommendations addressed the three basic subcultures or mind-sets of the health care field at that time: (1) a powerful one focusing on caring for patients dependent on providers; (2) a less powerful one focusing on caring for communities; and (3) an upstart, vigorous one focusing

Figure 1. Recommendations of the Committee on the Costs of Medical Care

I

The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.

II

The Committee recommends the extension of all basic public health services—whether provided by governmental or non-governmental agencies—so that they will be available to the entire population according to its needs. Primarily this extension requires increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only upon professional and administrative competence.

III

The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, *i.e.*, compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

IV

The Committee recommends that the study, evaluation, and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

V

The Committee makes the following recommendations in the field of professional education: (A) That the training of physicians give increasing emphasis to teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that postgraduate educational opportunities be increased; (B) that dental students be given a broader educational background; (C) that pharmaceutical education place more stress on the pharmacist's responsibilities and opportunities for public service; (D) that nursing education be thoroughly remolded to provide well-educated and well-qualified registered nurses; (E) that less thoroughly trained but competent nursing aides and attendants be provided; (F) that adequate training for nurse-midwives be provided; and (G) that opportunities be offered for the systematic training of hospital and clinical administrators.

Reprinted from *Medical Care for the American People*, 1932, Publication No. 28, University of Chicago Press.

on educating the health care workforce, or at least the emerging professional segment. A fourth recommendation addressed the next key subculture that was being born at the time: the one focusing on group payment.

An effective approach to community coordination in the current period starts with the premise that every element of a community's health care system is part of one of these four well-defined health care subcultures, each of which makes a significant contribution, but usually with a somewhat self-serving and too limited perspective on health care system development. Coordination within and among these different subcultures is the essential element of an effective health care system that is missing in this nation's health system; it is this deficiency that must be addressed in any effective health care reform initiative. Miscegenation among the cultures is the obvious answer, as one of my advisors has suggested, but reform cannot wait that long! A systematic approach to coordination in every community, as suggested by the CCMC, will also take a long time, but incremental progress is possible. With strong support and community control of increasingly scarce resources and money, coordination may accelerate more rapidly than past history.

COMMUNITY COORDINATION

The CCMC recommendation that agencies be formed in every state and local community to exercise study, evaluation, and coordination functions, with special attention to coordination of rural with urban services, was hardly developed in any detail in the CCMC's massive studies. In fact, the research and evaluation functions are not discussed at all, in contrast to the treatment of coordination. Even with respect to coordination, the CCMC focuses primarily on identifying gaps and duplications in needed facilities and services, with little or no attention to reform and reconfiguration of uncoordinated and duplicative elements within, as well as among, independent entities of the community's fragmented health care system. With a broader perspective on the coordination function at the community level, this recommendation appears to be one of the most important keys to effective health care reform.

The CCMC emphasized that local coordinating agencies, as contrasted with statewide agencies, must rely primarily on education and persuasion rather than authority. In every instance, however, the local coordinating bodies that were subsequently

created were given authority to play a key role in the control of scarce capital resources, resources that the coordinating bodies did not generate. Experience demonstrates conclusively that the control function always undermines the coordination function, except within highly structured management organizations. With a broader definition of the coordinating function, it becomes clear that at the community level, this function is best organized completely separate from—but carried out in close conjunction with—those who have the control function.

Within most independent corporations, the coordination function can be linked much more closely with the "command and control" function, but here again a broader concept of the coordinating function is required than simply avoiding duplication and identifying gaps. The key function of the coordinating role is helping to find and develop more productive relationships among separate elements of the system—both internal and external to individual organizations—in achieving unifying goals and missions.

Without active coordination among the various elements of the health system addressed in the other CCMC recommendations, it is unlikely that any reform proposal will work effectively. As the CCMC recommended, this will require an effective agency to exercise the coordination function in every community. Unfortunately, there currently are no outstanding models and little consensus as to how to proceed.

In the 63 years since the CCMC recommendations, the nation has witnessed a series of initiatives designed to establish a coordination function at the community and state levels, starting with the Hill-Burton legislation right after World War II through the legislation establishing health system agencies more than 30 years later. In between, there were the voluntary hospital planning agencies supported by federal funds, comprehensive health planning agencies, the regional medical programs, and a series of similar initiatives that addressed various aspects of coordination on a less comprehensive basis. Today, almost all of these entities are gone and forgotten amidst discussions of health care reform. It would appear that the many failures all reflected disregard of the basic position of the CCMC with respect to the coordination function as educational, involving persuasion rather than authority.

Beyond that, the common approach to community coordination usually identified communities as having "needs" that can be expressed in terms of resources to be assigned to one or another of the various independent organizations serving the community. In the most mechanistic marketplace application of this set of

concepts, coordinating agencies were for a time involved in awarding certificates of need (CON) to competitive applicants who could then turn around and sell or trade a CON to one of the other organizations, a scenario more commonly seen in professional sports.

Why the "Needs" Approach Fails

As we now know, the fact that people have personal needs does not mechanically translate into the notion that communities have explicit "needs" for any specific resources. The only thing that a community really needs is a responsive, community-controlled, coordinated health system closely linked with a coordinated regional network. Expressing community needs in terms of specific resources rather than in terms of mission-driven, coordinated systems responsive to "real people's" problems inevitably fails. That approach implies a dynamic relationship between the community and health service resources, in which the system is always shaped by the resources rather than by the health status, health problems, and health perceptions of the people. Much experience in the intervening years appears to be conclusive that this approach invariably assumes a configuration of services and relationships that is dominated by various decent but dated (almost inevitably out-of-date or too far ahead!) professional standards that, in themselves, are the major obstacle to effective reform.

The Problem-Solving Approach

A more useful approach is to: (1) visualize a reformed community health system bringing the resources together to attack and solve specific health problems of the people in a coordinated approach rather than designed to meet some theoretical concept of needs; and (2) develop mechanisms that will enable the community health system to move toward the coordinated vision on an incremental basis. Every opportunity to improve the health of the people in a community and to conserve community resources—every problem that the health system faces and every weakness in the health system—reflects the fragmentation and lack of coordination in problem solving of the community's health system as a whole, as well as the lack of coordination within almost all of the various component organizations that make up the system.

The problems and the opportunities are much broader than is reflected in the obvious duplication of resources among independent organizations: different hospitals, the health department, the medical school, the voluntary health organizations, community groups, industrial medical programs, insurance organizations, and more. Each of these to some extent deals with many of the same specific problems as other organizations, but with different and frequently conflicting approaches. Equally significant—maybe more so in most instances—is the lack of coordination of various elements attacking the same problem from different perspectives within the same organization.

An obvious example is the approach of hospitals and medical groups on the one hand, and the approach of insurance organizations on the other, to conserving resources consumed in unnecessary, frequently counterproductive and expensive inpatient care. Both organizations employ skilled staffs to second-guess or otherwise influence the behavior of physicians and their patients, two skilled staffs who often are required to spend more time trying to influence each other than engaging in any constructive activity. Think of how many ways some of these professionals could be spending their time more productively in improving health care in this country—or overseas in underdeveloped countries—if these fragmented activities in two different organizations could be consolidated. Or better yet, think of how much costs could be reduced as service is improved by eliminating these activities entirely as a result of more effective coordination among the caregivers themselves.

Literally thousands of other less obvious examples can be cited by experts trying to deal with almost any specific health problem in almost any community. Here are just a few.

Instructive Example 1: Immunization of Preschool Children

In most communities, there are at least three uncoordinated approaches to dealing with the problem of immunizing preschool children with the result that few communities have a success rate much higher than 50 percent. The *patient care approach* concentrates on building the vaccination procedure into routine pediatric care; the focus is on the management of the individual patient's care and the power of the patient-physician relationship. The *community care approach*—the public health or community benefit approach—is more visible, with a population focus rather than a patient care focus, relying on a variety of community

organizations to manage to influence the behavior of the parent population in the community and often creating convenient immunization sites in the community to supplement the services of physicians' offices and clinics. The *care of an entitled population approach* also has a population rather than a simple patient care focus, but manages much more specifically to eliminate the obstacles interfering with the immunization of specific children within the entitled population, ideally employing staff charged to ensure immunization of each entitled child, supported by an up-to-date patient information system.

. . . resistance to collaboration tends to be stronger within the same organization . . . [than] among individuals from the same subculture who are employed by independent organizations.

My own experience as a member of the governing body of an outstanding organization that employs all three approaches simultaneously has demonstrated two things: (1) that none of the three approaches alone is likely to get the job done and (2) without effective coordination, the combined result of the three approaches is little better than can be achieved by any one operating alone. The waste of valuable resources in uncoordinated approaches to the same problem is quite evident.

But this experience led me to a third and possibly even more important conclusion based on my efforts to encourage a coordinated approach to the immunization efforts within this organization, in the absence of strong support from the executive management team. The three approaches to immunization reflect quite distinct approaches to health care generally—really quite distinct subcultures within the health field—that resist collaborative initiatives. Furthermore, this experience demonstrated to me that such resistance to collaboration tends to be stronger within the same organization, as contrasted with the lesser resistances to collaboration among individuals from the same subculture who are employed by independent organizations.

The benefits of a collaborative approach to immunization were quite obvious to everyone, not only in terms of results (the proportion of the children who would be immunized) but also in terms of costs, which could be greatly reduced with a more coordinated approach. Unfortunately, the executive management team had more pressing problems to deal with and valid reasons to believe that overcoming cultural barriers to effective coordination

in this instance would be quite difficult and time consuming and possibly even counterproductive. Without strong commitment from the top or staff trained to deal with cultural differences, there was no alternative but to abandon the collaborative approach within this organization.

The example of immunizing preschool children could be duplicated any number of times and in relation to almost any health problem that is found among populations and communities—heart disease, cancer, or stroke—if one defines health problems in classical medical terms. In a more community health-oriented typography, one could identify such health problems as AIDS, violence, alcohol and drug addictions, family decay, poor nutrition, teenage pregnancy, the infirm aged, limited access to care—you name it! With coordination and community partnerships, almost any health problem can be attacked with much more effective results and much fewer resources.

Instructive Example 2: Care of AIDS Patients

A less obvious and lesser known dramatic example involves the care of AIDS patients. A few years ago, I was involved with a Blue Cross–Blue Shield Plan that was quite concerned with the increasing proportion of its expenditures absorbed by the care of AIDS patients. At that time, it was estimated that the Plan's enrollees included about one-third of all of the HIV population in the communities it served. There was concern that the increasing use of services by these enrollees could bankrupt the plan in the years ahead. After some unproductive exploration of a variety of unilateral approaches to limiting benefits and to discouraging enrollment of HIV individuals, the plan developed a coordinated approach to the problem that has become a model for others. This approach has greatly improved the quality of life of the AIDS patients and reduced the cost of serving them by almost 50 percent.

The solution involved employing a staff of well-qualified AIDS counselors who were experts on (1) the care of AIDS patients, (2) the dynamics of the AIDS community, (3) the dynamics of the health care system, and (4) the nature of the unique relationships of an AIDS patient with the health care system. For all cases in which the patient and the patient's physician would take advantage of the services of this team of counselors, Blue Cross–Blue Shield guaranteed elimination of *all* benefit restrictions. Whatever would improve the quality of life of the AIDS patient would be paid for. (Imagine the initial reaction of the plan's CFO to this "far-out,

crazy" notion!) The plan paid for services that had never been thought of as even closely related to medical care, and the volume of inpatient care and other ineffective, expensive "covered" services declined precipitously. The plan's AIDS staff also became a major force in the community in various activities designed to limit the spread of this plague. Through a three-way coordinated approach to patient care, care of the community and care of an entitled population, the problem is being brought under control with substantially fewer dollars and obviously superior results in terms of patient care and health status.

Instructive Example 3: The Infirm Aged

The AIDS example has broad application beyond the AIDS population: At the age of 75, I aspire to live long enough to become a part of the infirm aged population. I am increasingly sensitive to the similarities between the infirm aged population and the AIDS population. The natural body defenses are running down in both groups, we are both becoming less independent and more subject to the ravages of various diseases, and both of us have about the same life expectancy. And among both groups, the medical care system typically responds to our inevitable debilitation in the same way: with massive application of complex procedures that interfere with the quality of our lives, especially during the last six months of life, procedures that do very little good and greatly increase the cost of health care. Early experience with social HMOs and other coordinated approaches to the infirm aged suggests that a similar approach to that described above for AIDS patients would greatly improve the quality of life of the infirm aged and greatly reduce the costs of serving them.

Physicians and other caregivers tend to do for us what they were taught to do, what they are comfortable with in the subculture in which they were raised and trained, and frequently with little explicit attention to outcomes. This is generally true for all types of caregivers, whether Native American healers or board-certified specialists. In this period of health care reform, many of the various health care subcultures of the communities are quite foreign to the various health care subcultures that have shaped the behavior and attitudes of most of the caregivers and health care managers. In terms of movement toward health care reform, however, the incompatibility among the various health care subcultures may be an even greater handicap than the cultural incompatibilities between consumers and caregivers. In most such situations—as is clearly the case with AIDS and the infirm aged—

those caregivers who are empathetic with the consumers are almost as culturally separate from their fellow caregivers as is their patient population.

The Challenge of Separate Subcultures within the Health System

As previously indicated, in the 1930s there were three quite distinct subcultures in the health field, each with its own goals and objectives, management methods, education, information systems, reward systems, evaluation methodologies, professional associations, and financial requirements—each going its own way. These were the subcultures that emphasized caring for patients, caring for communities, and "caring" for education and research. Today, we have a fourth subculture that focuses on caring for enrolled populations.

These distinct subcultures tend to be concentrated in organizational forms that appear to be more committed to each subculture's survival than to an effective health care system for the community. The hospital is still the current center for the patient care subculture, though possibly not for long. The health department is the center for the community care subculture. Obviously, the academic medical center is the center for the education and research subculture. The HMO is the center for the subculture focusing on caring for enrolled populations.

But there is no clear-cut rigid separation. Although there is no "melting pot," elements of all four subcultures can be found in all four types of organizations, typically with less interaction and real communication among the different subcultures within the same organization as there is between elements of the same subculture found in different organizations. As previously noted, often these different subcultures are attacking the same problem from quite independent perspectives and resources, and with little awareness of other approaches from other cultural perspectives, and sometimes even with adversarial relationships to the others—and with unbelievable waste of scarce resources. What is required is a mechanism for integrating these efforts of the different subcultures throughout the community's health system, within and across various organizations.

The approach of attempting to develop specialization of function of various organizations, so that patient care organizations only do patient care, and community care organizations only do community care, as suggested by some analysts, inevitably will

lead to suboptimal results (see Rundall 1994). When dealing with the health of the people in a community, every organization must necessarily continue to have multiple goals and activities, reflecting not only the contribution of its unique perspective, but incorporating contributions from other perspectives most commonly associated with other organizations. As a result, the broad potential of coordination processes in health care reform involves a number of dimensions, especially:

1. Exploring the potential of more effectively merging similar clinical and other processes associated with different subcultures within the same organization to eliminate duplication of effort. Some successful examples can already be found in the coordination of patient care and medical education. Some outstanding community-oriented primary care initiatives (COPCs) even represent successful coordination of patient care, medical education, and community care. When these are capitated, the stage is set for comprehensive coordination.
2. Developing seamless approaches to the application of different methodologies as different organizations attack the same health problem or serve the same family.
3. Exploring the relative efficiency and effectiveness of the different methodologies with respect to any specific health problem, so as to be able to allocate resources among the different methodologies most effectively under varying circumstances. In almost all instances, more productive and less costly results will be achieved by coordinated emphasis in all organizations and subcultures on community care initiatives, on prevention and health education, on primary care, and on empowerment of patients and their families as the key health providers.

The methodologies of the distinct subcultures have quite different starting and ending points. Typically, the patient care methodology starts and ends with patients. By contrast, the entitled population methodology goes beyond that to incorporate an explicit population of individuals or individual families. The community methodology goes beyond individual patients and the entitled population to encompass all of the people in the community and their interactions through various community organizations.

The problem is made even more complicated, and the opportunities for incremental improvements even more pervasive, by the existence of inadequately coordinated subcultures within the major categories of each so-called subculture, most obviously within the patient care subculture. Within the physician category, the lack of effective coordination between specialists and those in primary care is notorious. But so is the lack of coordination between family practitioners and other primary care specialists such as internists, pediatricians, and obstetricians—not to mention the immense potential for better care for less money from more effective coordination between physicians and various categories of nurse practitioners, or that between graduate nurses and ancillary personnel. This list goes on and on, down to more effective coordination between professionals and the basic caregivers who can provide the most tender-loving care at no cost whatsoever to the health care system, and with no apparent conflicts of interest—that is, the patient and the patient's family.

The Contribution of "Displaced" Professionals

In almost all situations, the greatest potential for improving coordination among independent organizations is to be found among those professionals from one of the subcultures who are employed by organizations identified primarily with some other subculture. They are the key links. Every organization that I have encountered employs them. Very few organizations recognize and exploit the unique potential of these types of individuals. As organizations become more involved in developing seamless approaches not only to patients but also to care of enrolled populations and communities, these individuals tend to achieve recognition and leadership roles. Almost always, they are involved in informal collaborative activities with counterparts in other organizations that provide the best pathways to more formal networking arrangements among the organizations involved.

The Contribution of Modern Computer Technology

Modern computer technology can contribute to a more effective coordinated community health system in two important ways. First, with modern computer technology and the vast amount of information available, it is theoretically a fairly simple task to design a reformed health care system for any community or region in which theoretically all obstacles to effective coordination among

and within the various cultures and subcultures have been overcome. In this imaginary reformed health system, the various cultures and subcultures function harmoniously, solving health care problems while conserving resources that could be used in other aspects of the public welfare. With only a modest degree of imagination, it is not difficult to design a theoretical health care system that will provide dramatic improvements in health status of the people, and with sharply reduced expenditures by the health system, even lower than is found in most other countries with advanced civilizations. Such fantasy models will never be achieved, but they help to focus on concrete steps that can be initiated to address some of the obstacles. Second, as modern computer technology becomes ever more user-friendly and available within the community and incorporates more useful health information, the consumer and the family can become ever more self-reliant as their own health providers, requiring less and less time from the professional caregivers on whom they must rely for supervision and guidance.

But moving to some detailed, artificial utopian health system is not the immediate answer. Rather, what *is* required is commitment to a much less detailed but inspiring vision of a coordinated system that can take shape through incremental advances in coordination, evolving into a less fragmented system dedicated to the public good.

In most communities, a move in that direction will require the creation of a strongly supported, specific entity with a long-term goal of promoting community coordination by breaking down cultural barriers within the health system, as well as the barriers between the health system and the rest of the community served. This is the key missing element in community health systems in this country.

ORGANIZING AND MANAGING A COMMUNITY COORDINATION ENTITY

As recommended by the CCMC, agencies should be formed in every community to organize and manage the coordination function. Coordination is a basic requirement for improved community health status and for narrowing the gaps between the health status of the more and less privileged segments of the community, as well as for conservation of resources absorbed by the community's health system. Although achieving more effective coordination is a never-ending process that must be carried out by

dedicated individuals associated with the various organizations within the existing health system themselves, the pace of change for real reform calls for establishment of a unique, strongly backed, highly credible entity designed specifically to facilitate the process.

In short, any community that can achieve massive coordination within its health system—and this cannot be achieved overnight—can become among the healthiest in the world and spend much less money on health care service. No lesser vision is likely to ensure real health care reform or a successful venture in coordination.

Unfortunately, there is no example of an agency for coordination, as was recommended by the CCMC, in any community, although many community-based organizations do promote and encourage coordination in limited contexts. Now is the time to explore the potential functions, organization, accountability, and financing of such an entity.

Functions

The functions of a successful community coordinating entity will provide the community with the necessary missing elements to accelerate coordinated programs. These functions should include at least the following: articulating a vision of a more effective health system, maintaining credible information systems, developing an authoritative analytical capability, providing shared staffing and technical assistance, publicizing successful initiatives, developing standards, conducting evaluation and research, and serving as a model of community commitment.

1. Articulate a Vision of the Future Community Health Care System

A vision of a healthier community, healthier people, and more coordinated and effective health services for less money can become a powerful force for reform as it is embraced by ever broader elements of the community and of the health system itself. Those who help to get the coordinating entity started should be fully committed to such a vision before the agency begins to function. This means not only commitment as potential board members of the new entity, but also in their ongoing capacity in the community's health system. Given the current level of cynicism about community initiatives in health care, however, a great deal of effort will be required before the idea of an ever more coordinated health system becomes an essential element of com-

munity life and a driving force for reform within the community's various organizations. In addition to articulating the vision at every opportunity, the coordinating entity should be in a position to assist any element of the community to formulate its own unique role in helping to turn the vision into reality.

Without continuous support and reinforcement from the coordinating entity, the vision of a reformed health care system throughout the community will tend to be too short-term and excessively self-centered to be as useful as possible. For many elements of the community's health care system, which are necessarily focused sharply on getting things done right now, adapting current planning and programming to a far-off vision of the future will be very difficult, frequently reflecting more than one false start that may be expected rather than condemned as proof of untrustworthiness. A wide variety of community transactions should be linked with community goals as soon as possible to accelerate acceptance of the reality of the shared vision of the future.

2. Maintain a Credible Information System

Community coordination will proceed most rapidly when based on publicly available, highly credible information about the characteristics and dynamics of the community's fragmented health system. An information system should be designed to provide useful information about opportunities for community coordination, including data permitting the establishment of quantifiable goals for coordination initiatives and measurable results of these initiatives over time in a continuous quality improvement process.

The coordination entity should avoid becoming directly responsible for the collection and processing of new sources of data since almost all the data required should be available within the community's existing health care system. Relying primarily on secondary sources and special sampling studies, the entity should become the recognized and easily accessible source for authoritative information that relates to the potential for improved coordination for better health and more effective health services and for tracking results.

3. Develop an Authoritative Analytical Capability

Closely linked with the information system, the coordinating entity should develop the most authoritative analytical capability in the community with respect to the facts relating to coordination

opportunities and results. The reputation for objectivity should be guarded scrupulously, especially in the early stages, leaning toward excessively cautious interpretations of trends and results.

4. Provide Shared Staffing Services Relating to External Affairs for Governing Bodies of Independent Organizations

Health care organizations have a long history of using shared services—group purchasing, shared collection systems, shared information systems, not to mention a variety of shared clinical services. Shared staffing with respect to external community issues facing the boards of directors and boards of trustees of independent organizations making up the community health system would appear to be a practical and useful extension of this practice. This approach should result in more effective staffing at lower costs, and with less likelihood of obstacles to coordination as a result of conflicting staff work on the same topic by different staffs.

Currently, staffing for the governing board's responsibilities in relation to external affairs is provided by some combination of the work of the executive management team in its spare time and of outside consultants. The first approach has all of the difficulties associated with staff work carried out by individuals not explicitly trained for the work and who lack the appearance of objectivity required for assembling the necessary issue papers relating to the external environment. The common alternative of supplementing the work of the management staff with the use of outside consultants generally costs much more, especially if the consultants take the necessary time to become thoroughly acquainted with the existing community health system and adapt their analysis and recommendations to the unique community environment.

Many CEOs of large organizations have employees reporting to them who are dedicated to staffing the board and its committees, but these employees are involved almost exclusively in arranging meetings, generating and distributing minutes, and performing other housekeeping tasks, as contrasted with staff work on substantive issues to be considered by the board.

Contracting with a community coordinating agency provides a number of advantages to the CEO over the use of outside consultants: (1) availability of a permanent, objective staff who have explicit expertise in coordination processes, know the unique characteristics of the community and the community leadership, have established credibility, and are trained to avoid involvement in the decision-making processes of the board and executive

management team and the caregivers; (2) access to continually up-to-date information about the community's health system and ongoing coordination activities; and (3) lower costs than outside consultants. This approach to staffing the board's involvement in external affairs has the added advantage of giving the appearance of a deep commitment to community coordination as contrasted with narrow self-interest. Of course, outside consultants can also be used to advantage whenever that approach is indicated.

The shared staffing approach requires the most sensitive interaction between the shared staff and the staff of the community organization being served. The shared staff must demonstrate an ability to handle confidential information, to respect the governing board–executive management team relationships, to avoid involvement in internal affairs and current operations unrelated to the explicit assignment, and to resist the tendency of some governing boards to expect the staff to make their decisions for them.

5. Provide Technical Assistance

Beyond staffing help with respect to governance issues, technical assistance staffing can be provided to any community organization in any aspect of its efforts to promote greater coordination within the organization, as well as outside of it. In almost any community of any size at any point in time, any number of consultants are engaged in the kinds of assignments that the executive staff does not have the time or background to carry out by itself, which indicates there is a demand for the service.

6. Provide Staff for Communitywide Coordination Initiatives

Not infrequently, a common decision will be made to explore communitywide, broadly sponsored opportunities for greater coordination with respect to some particular health problem or opportunity. This might include community approaches to trauma, long-term care, managing capitation, or almost anything else. Here again, the coordination entity is in a position to provide objective, well-informed, credible staffing for such initiatives.

7. Serve as a Model of the Power of Community Commitment

In a period of health care reform based on a vision of a comprehensive coordinated system, reliance on control of specialized resources and of independent organizations becomes an ever less

reliable method of maintaining influence and power. This approach to power will lose its effectiveness, as contrasted with (1) the power of commitment to a vision of a more effective, coordinated community health system, (2) the reputation of basing organizational decisions on objective analysis and on communitywide goals and objectives, and (3) demonstrated respect for the prerogatives of others. The transition from "command and control" to "coordinated decision making" will be very difficult for the governing board and management leadership of many strong individual organizations in the community's health care system. In that respect, the coordination entity should work very hard to serve as a model in its own activities, demonstrating through its increasing strength that power is shifting away from the "control freaks" to those relying on a broader perspective. Avoidance by the coordination entity of even the appearance of a command-and-control approach is essential. The coordination entity must avoid all efforts of others to pass on any decisions within the community's health system, especially with respect to capital investment, allocation of scarce resources, and downsizing. As the coordinating entity becomes increasingly effective, the pressures to make decisions for others will be very strong, but it must be resisted.

8. Publicize Successful Coordination Initiatives

Early successes in coordination efforts are the best stimulus for expanding the commitment throughout the community to the development of a more effective coordinated health care system. The coordinating entity should devote significant resources to searching out and publicizing successful efforts, whether or not the coordinating entity has been directly involved.

9. Develop Community Partnership Standards

One of the strongest motives of the leadership of any health care organization is to be recognized as conforming with the highest standards. Most will do almost anything to avoid being identified as second-rate organizations. This is demonstrated, for example, in the resources and energy devoted by most hospitals and other organizations to meet the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), despite growing dissatisfaction with that organization.

Most hospital executives who tend to view community collaboration as virtually impossible all conform with the single

community collaboration element of the JCAHO. The fact is that a JCAHO-accredited hospital can turn its back on its community and function exclusively as a competitive body repair shop and meet all of the highest standards, with one exception: The hospital must have a community disaster plan that goes beyond body repair work on the victims brought to the hospital. This point was brought home to me some years ago when I was working on promoting greater collaboration between the only two hospitals in Sioux City, Iowa, and was told that collaboration among these two hospitals was an impossibility. Just then, an airliner crashed at the airport and the community's disaster plan went into effect and functioned superbly, in conformance with the joint planning outlined in the hospitals' response to the JCAHO requirement. Collaboration worked with hardly any competition whatsoever (except for some competition for national TV exposure). This superb collaborative exercise touched almost every aspect of both hospitals and lasted for over a week before "normal" competitive marketplace relationships took over again.

Because of the power of voluntary standards, there are standards for almost every aspect of health services systems and many incentives tend to be built around these standards. Nevertheless, it appears to be clear that the drive to conform with voluntary standards is an important force in itself. With or without accompanying incentives, the notion of standards of community partnership would appear to have great potential in structuring and accelerating community coordination reform initiatives within and among the community's health system organizations. Unless or until national standards are effectively administered by some national accrediting body, the coordination entity can take the lead in assisting community organizations to develop and test such standards. In any event, the entity should provide extensive community recognition to those organizations committed to partnership standards.

10. Conduct Research and Evaluation

The coordination entity provides a logical focus in the community for receiving and distributing funds for research and evaluation that may be expected to be increasingly available in the period just ahead as national interest in the nature of effective community coordination processes can be expected to grow.

Selecting a Location, Funding, Governing, and Staffing a Community Coordination Entity

A whole series of questions come to mind with respect to a community entity committed to promoting a more coordinated community health system—location, funding, governance, and staffing and more.

Location

Where should a community coordination entity be located? Should it be totally independent? Or should it be a subsidiary or element of some existing organization? If so, which one? Or should it exist only in the minds and hearts of all of us? There is probably no one right answer for every community at this time. Each alternative has its advantages and disadvantages.

1. *Independent organization.* The advantages and disadvantages of creating a new organization are well-known. The major disadvantage is tied to the necessity for greater initial financial support and the time and risks involved in the birth of a completely new organization. The major advantages relate to credibility and visibility and degree of independence. In most complex communities, an independent organization would appear to be the only acceptable alternative.
2. *Existing organization.* Very few organizations within the community's health system would be able to overcome concerns about self-service and bias. Conceivably, some communities might consider the public health department, although the perceptions of the limitations of a government agency by key elements of the health system would be difficult to overcome at this time. Less controversy would be involved in selecting the United Fund, the Community Foundation, the Council of Social Agencies, or a community college. The business health coalition, the Economy League, the hospital or health council, the Academy of Medicine—all would have to overcome perceptions of narrow self-interest. Depending on the history and leadership, however, in some communities any one of these might be feasible.

   Another alternative is to establish the entity within an obviously neutral community organization, such as the public library. It is well to keep in mind that

the most powerful entities these days in the congressional debates on health care reform are such entities as the Congressional Budget Office, which has no authority at all. Power rests on its commitment to objectivity and reliance on credible analytical capability.

3. *Community care network.* In communities served by only one community care network that is clearly committed to designated communities and governed accordingly, the coordination entity could most logically exist within the network framework. That would appear to be the most logical approach and would help to ensure that the network was truly committed to the community.
4. *Virtual reality.* Since the key actors and actions with respect to community coordination are within the various existing organizations that make up the community's health care system, there are real advantages to having the entity exist only within the minds of those associated with these organizations. In the earliest and latest stages of the evolution of a reformed, thoroughly coordinated community health system, the newest technology associated with "virtual reality" may be the best approach. Those who have been exposed to virtual reality technology, in improving their golf game for example, tell me that there is no more powerful approach to influencing and changing behavior.

Funding

As the entity develops increasing credibility, most of its activities can be funded from fees for services and project grants from a variety of sources. Initially, however, significant funds will be required for start-up costs and for an endowment fund to ensure stability and continuity. Provision of such funds by community-based foundations, corporate foundations, and other sources of philanthropy can also be supplemented by contributions from various elements of the community health system itself. Start up without adequate funding for the first five years would in almost all cases be premature.

As annual health care expenditures per capita in this country approach $4,000, health expenditures associated with a population of 25,000 amounts to $100 million. For a population of 250,000, expenditures are approaching $1 billion. An investment by the community of just one-quarter of 1 percent of this amount

in a community coordination entity should provide a budget with potential for real payoff.

Governance and Staffing

Ideally, the chair of the governing body of the coordinating entity and the CEO should not be associated with any specific element of the community health system. Beyond those two, there may be as many advantages as disadvantages to drawing on individuals associated with the health system. Particularly with respect to start-up staffing beyond the CEO, there are major advantages to drawing carefully on the existing organizations for full-time staff, temporary or part-time project staff contracted with individual organizations, and volunteers contributed by these organizations.

LEADERSHIP FOR COMMUNITY COORDINATION

The Nature of Leadership

The word "leader" has two general connotations: (1) being ahead of or in front of others and (2) having strong influence on others. The first obviously does not apply here. Being ahead of everyone else in coordination is a contradiction in terms. Leadership in community coordination refers to the second notion, exercising influence on others. That means that all of us, except those who have no potential influence on anyone at all, have some potential for leadership in community coordination. We can exercise this influence within our immediate spheres of influence (family, work unit, neighborhood, church, union local, professional association, etc.) and also, with lesser impact and greater importance to community coordination, in related spheres of influence where we may not be so dominant (the organization in which we are employed, the school district, the local government, the health plan, etc.). In immediate spheres of influence, our leadership may depend as much or more on the power or authority associated with our designated role as on the power of the position that we are urging on others by example or by persuasion. In related spheres of influence, the power of persuasion will be more important.

Any of us who have a vision of a reformed health care system based on greater coordination of fragmented elements have myriad individual leadership opportunities to help others to share this vision and to explore specific collaborative initiatives within their spheres of influence that will move the health care system in

more harmonious patterns and confirm the validity of collaborative approaches. Equally important and often forgotten is our followership potential. Frequently, providing leadership in one's own sphere must be closely linked to committed followership with respect to the broader spheres that we may touch.

With respect to organizational leadership, there is much to be said, but nothing that is not said superbly in the leadership positions of the American Hospital Association (1990, 1994) that were developed initially in 1982 and subsequently updated. The leadership responsibilities of health care organizations are spelled out in detail, as well as the explicit leadership responsibilities of the governing boards, executive management teams, and caregivers. These responsibilities are outlined and emphasize interrelated responsibilities to promote coordination both within the organization and in its external relationships. Internally, the leadership initiative rests primarily on the executive management team. Externally, the leadership rests primarily on the governing body.

Overcoming Current Obstacles

There are many obstacles to be overcome by any community moving toward a less fragmented and more coordinated health system. Of major importance are the obstacles presented by forces outside the community. Of these, the most important are: the threat of antitrust litigation and the fragmented approach of the national accreditation, licensing, and standard-setting authorities, as well as the payment practices of the governmental and nongovernmental financing organizations.

Approaches to overcoming these obstacles can and should be incorporated into reform legislation that can not only remove these obstacles but also provide additional incentives for accelerated community coordination. Pending the enactment of such legislation, there are many ways that communities can increase coordination without risking antitrust litigation and by pooling of fragmented health care revenue through capitation and other techniques. With respect to avoiding antitrust litigation, the most obvious approach involves assigning a major coordinative role to the local governmental authorities. Beyond that, comprehensive community involvement is the key. The record should be clear that the only nonparticipants are those who "exclude themselves."

The other obstacles to moving ahead with coordination initiatives primarily reflect various mind-sets within the community that interfere with moving ahead: ignorance of the risks

of inaction and of the potential rewards of a coordinated community effort, skepticism about results, false expectations about what can be achieved quickly, and finally, the insecurity or greed of entrenched interests. All of these obstacles must and can be overcome through fairly well-known processes of community organization and mobilization that involve all elements of the community. It is not easy, but it is not impossible either. With respect to greed, for example, any community or community organization can accept this very human trait and even exploit it in the community interest through tough business contracts, but it should resist policy formulations based on greed as the dominant force.

Reprise: The Role of Incentives

The health care system is an extremely complex set of elements, none of which can function effectively in isolation, even in pursuing relatively simple self-serving goals. All elements are dependent on a series of explicit or implicit contracts or transactions with other elements, some of which are expressed in terms of money transactions while others are expressed in other measures; some of these can be translated into money terms by economists only with great difficulty and some loss of reality. These contracts and transactions are the essential elements that hold the health care system together.

In terms of incentives, the key to improved coordination in the community interest is to build community benefit into more and more of these contracts and transactions, increasingly entered into by organizations and individuals who accept the community as a whole, as one of their equal partners. Community considerations can be incorporated in terms of money or other kinds of trade-offs, and they can be built in through positive or negative incentives.

As is well-known, money talks and is the key measurable factor in positive and negative incentives in contracts and transactions. Opportunities to receive more money or spend less represents the most common positive money incentives. Conversely, the threat of receiving less money or having to spend more of it represents negative incentives. Although such money incentives are very powerful, they are even stronger when linked to other important human, institutional, or organizational imperatives, such as freedom of action and self-determination, pride in one's work, public recognition, but especially community benefit—all

of which can be built into contracts and transactions in either positive or negative terms.

Opportunities to build community coordination incentives into health care transactions and contracts are almost limitless at this time. One of the best known and most effective examples is the commitment to community rating for health insurance premiums by the industrial and health care leadership in Rochester, New York. Eastman-Kodak and other major corporations have contracted for health care services for their employees and dependents on the basis of the average community rate, which is significantly higher than what they could readily negotiate with insurance companies by making full use of their power in the marketplace. In return, the hospitals have agreed to work together with industry leadership on a communitywide approach to providing cost-effective care. As a result, although the corporations continue to pay at higher rates than they could easily bargain for, their rates in Rochester are significantly lower than they have to pay in other communities where they have major plants but where there is not the same community commitment by either the corporations or the hospitals. By making the community interest a major partner in the contracts, all parties have benefited. The same approach can be built into any transaction into which various elements in the health care system enter, including contracts and other transactions with investor-owned corporations. In every case, the parties can raise the question as to how this transaction and contract can include a factor to benefit the community as well as the parties involved.

Opportunities to build community coordination incentives into health care transactions and contracts are almost limitless at this time.

To my knowledge, no investor-owned corporation has ever indicated a willingness to put community benefit goals above its basic obligation to the stockholders, but all are interested in any arrangement that has promise of benefiting both. In fact, the health care field has a long history of financial transactions with investor-owned corporations serving both stockholders and community benefit organizations, corporations with no interest in taking responsibility for overall community health care policy and accountability. Examples that come to mind are: food service, housekeeping, and laundry corporations; hospital management firms; insurance companies and HMOs; hospital supply firms;

emergency services; radiology services; and many, many more. Privatizing specific functions is in the best traditions of the American health system whenever it can do a better job; privatizing or doing away with community governance and accountability is not.

A FINAL NOTE

This article developed from an observation about the lack of historical perspective in the debates about health care reform during the past few years. For many of the active participants in the current debates, the fact that almost all of the current ideas—and then some—have been discussed in detail for at least 60 years may come as a surprise. Looking back at just one specific reform proposal—community coordination—that has been neglected for many years, I have attempted to provide a fresh perspective on how this particular reform initiative can be adapted to the current environment, with significant potential benefit. Irrespective of the merits of this particular effort, I hope that it might stimulate others to reexamine the recommendations of the Committee on the Costs of Medical Care and of other significant reform proposals by a variety of national commissions and other groups in the health care field during this century. Beyond that, I hope the article might lead to a national conference or symposium devoted to analyses of historic recommendations for health care reform.

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References

American Hospital Association. 1990. *Imperatives of Hospital Leadership; Role and Functions of the Hospital Management; Role and Functions of the Hospital Governing Board*. Chicago: AHA.

———. 1994. *Transforming Health Care Delivery: Toward Community Care Networks*. Chicago: AHA.

Breslow, L. 1994. Personal communication.

Committee on the Costs of Medical Care. 1932. *Medical Care for the American People.* Pub. No. 28. Chicago: University of Chicago Press.
New York University. Robert F. Wagner School of Public Service. 1989. "Hospital Benefit Standards Program."
Rundall, T. G. 1994. "The Integration of Public Health and Medicine." *Frontiers of Health Services Management* 10 (Summer): 3–24.
Weeks, L. E., and H. J. Berman. 1985. *Shapers of American Health Care Policy: An Oral History.* Ann Arbor, MI: Health Administration Press.

APPENDIX: DEFINING KEY TERMS

In exploring the concepts involved in a systematic approach to community coordination and partnerships as key elements of health care reform, precise meanings are under development for some of the terms that are commonly used. The definitions of these terms are still being worked on, but the following notes may be helpful.

A community partner is any organization with multiple goals, in which the commitment to the health care of designated communities is at least equal to any other organizational commitments, such as to patients, to education and research, to physicians and other providers. Thus, the hospital trustee who always interrupts any decision-making process to ask, How is this good for the community? represents the very essence of appropriate governance of a community partner.

Coordination represents systematic linkage of elements within an organization or linkage of elements between and among different organizations to achieve shared goals of the elements.

Community coordination represents systematic linkages of elements to achieve explicit shared community goals.

Networks and **networking** refer to coordination between and among entire organizations, as contrasted with such interaction only between elements of organizations.

Community care networks refer to networks in which the network commitment to designated communities is at least as great as the network commitment to other goals.

Collaboration represents cooperative relationships among elements of independent organizations of a more informal nature, often not directly related to the overall mission, goals, or strategic plans of one or both of the organizations involved. Thus, physicians with medical staff appointments at two or more hospitals represent important collaborative linkages, whereas agreements among different hospitals with the same physicians as to their respective roles and interactions represent an important example of coordination. Collaborative activities such as referral relationships among physicians and other professionals, frequently unknown to the leadership of health care organizations, are pervasive in most communities and are the most important linkages that hold a community's health care system together.

Community, as used in this article, is especially important since it has so many different meanings in various contexts. The precise definition used here is that developed by the Hospital Community

Benefit Program at New York University (1989): "All persons and organizations within a reasonably circumscribed geographic area, in which there is a sense of interdependence and belonging." This definition emphasizes that there is no community without some forms of organization. A group of people is not a community for these purposes, no matter how much they have in common, unless there are some forms of organization. For our purposes, communities are necessarily defined geographically and may be large or small; however, the sense of interdependence and belonging tends to grow weaker to the point of diminishing returns as larger and larger geographic areas are considered as communities.

A community is to be sharply distinguished from a service area or a market from which patients are drawn, since these geographic areas should generally be much larger than any community that any health care organization can benefit to any measurable degree. As used here, the term "community" emphasizes the diversity of the elements that have a sense of dependence and belonging, especially reflected in the concern for the more disadvantaged individuals and organizations. Thus, the notion of the "physician" community or the "hispanic" community is quite a different use of the term. The important concepts reflected in those uses of the term "community" are expressed otherwise in this article, since they reflect an important sense of special interdependence and belonging that is usually stronger and more self-serving than with respect to the entire geographic community. For our purposes, these are best identified as interest groups rather than communities.

Community service of a health care organization is any activity that relates to the organization's community goals as contrasted with other goals. Most health care organizations are involved in much more community service through collaborative activities than the CEO (and especially the CFO) know about!

Community benefit is community service with an outcome orientation and is a new growing development, though still relatively rare. Community benefit is often identified as community service that supports tax exemption. This seems backward; in this article, tax exemption is viewed as an important support for community benefit.

Community health care system is a concept encompassing all the elements that relate to the community's health and their interrelationships. Some observers believe that most communities have a "nonsystem," but as Les Breslow (1994) has pointed out, "Just try to change something and you will know that there is a very strong system in your community!" Thus, our use of the term "community health system" is very much like geologists' use of the term "mountain system." In both cases, there is no necessary implication with respect to purpose; only God knows the purpose of a mountain system. In both cases, extremely useful insights result from systematic analysis that is not judgmental with respect to the purpose of the system or of its elements.

Culture as used in this article is almost synonymous with the term "mind-set," or more specifically as culture is defined by many sociologists: "The sum total of ways of living built up by a group of human beings and transmitted from one generation to another."

THE COMMENTARIES: A SUMMARY

This issue's commentaries provide a range of perspectives. Walter McNerney, Professor of Health Services Management at Northwestern University, confirms and extends Robert Sigmond's vision. Philip Newbold, President and CEO of Memorial Hospital/Health System in South Bend, illustrates how efforts to create "healthy communities" represent examples of community coordination. By drawing our attention to past failures and current realities, Drew Altman, President of the Henry J. Kaiser Family Foundation, injects a healthy dose of skepticism. All three commentators address the possibilities of collaboration within a competitive environment.

McNerney provides enthusiastic support for the lead article. He obviously sees that the time is ripe for the types of community efforts it envisions and refers to the many initiatives that are already underway across the country. For McNerney, the "pot...beginning to boil" is the impetus behind much of these efforts. While consumers may not have an in-depth understanding of the health care system, their frustration with it—both economically and socially—is increasing. Distrust is building, he argues, for even the most prestigious community health organizations—witness the recent round of challenges to hospitals' tax-exempt status.

McNerney acknowledges that considerable reforms have already taken place, driven by the actions of competing health care systems. However, he feels that certain voids have been left by these largely national organizations, voids that must be filled at the local, community level. It is in the local communities, ranging in size and character across the country, that the definition of health is being expanded beyond that typically embraced by the medical and health care system. An expanded definition of health demands community coordination and collaboration.

Finally, McNerney provides a list of practical suggestions on how to proceed and a cautious listing of potential obstacles in that journey. He reflects on the need for effective leadership and its role in bringing together competitive forces and differing subcultures for the community's interest.

Philip Newbold views the hospital as caught in the middle between two very dynamic and seemingly opposing forces. On one hand is the competitive model that has resulted in the very rapid development of integrated delivery systems. At the same time, hospitals are being drawn to a community mission that encourages collaborative ventures to improve community health.

For Newbold, health and health care must originate at the community level. He believes that health care cannot be reformed from the top; instead it is families, communities, and neighborhoods that create health. New models, indeed new ways of defining health, are needed. Like McNerney, he envisions a broader type of

health care, one that embraces social as well as economic concerns and in which health care can be delivered in churches, schools, and other community institutions. Newbold advocates that a new knowledge base is needed in order to foster a movement away from a sickness model toward one built on prevention.

As chair-elect of The Healthcare Forum, Newbold holds a leadership position in an organization committed to the "healthy communities" concept. His own health care system, while operating in a competitive environment, has embraced this concept, and his commentary contains concrete examples of collaborative efforts with the community designed to impact community health. They represent important incremental steps toward health reform.

Drew Altman reminds us that there is an important third force in the health care reform debate, government regulation. For him, the real struggle is between regulation and market forces. While the collaborative model is admirable, he is not convinced that it will play a significant role in health care reform. Many of the problems of our system, like the large number of uninsured Americans, are too large to be solved by any one community.

Like Sigmond, Altman reminds us to examine our past. Previous attempts at community coordination and planning have not worked, even though sponsorship has come from both government and private foundations. He outlines some of the reasons for these failures and suggests that the same forces apply today.

However, Altman does envision a role that communities can play amidst the current market-driven reforms. Solutions, he contends, will need to be tailored to local circumstances, and creative and proactive communities can forge a role in shaping how those changes will be applied at the local level.

Finally, Altman enumerates a series of questions prompted by our rapid shift to a business-oriented health care system that challenge all of us.

—M. E. S.

WALTER J. MCNERNEY

Community Health Initiatives Are Widespread, Challenging Our Sense of Civic Obligation

Bob Sigmond's assertion that community coordination is a key missing ingredient in achieving more effective health systems at the local level is worth our full attention. He brings to this issue a wealth of relevant experience in the financing and delivery of health services and as a pioneer in health planning at the community level.

Having had a modest exposure to community initiatives through, most recently, a program in Calhoun County, Michigan, I support Sigmond's basic point, although with a few elaborations that I will mention later.

Coordination Is on the Move

Despite pervasive changes in health systems across the country, from my perspective, the public in general and, specifically, buyers and providers of care in many communities are frustrated with fragmentation of care, rising costs, uneven access, shortages of primary care, inadequate information, and a lack of consumer input or feedback. Whereas there are few successes to point to, many communities are beginning to address these and other issues through community studies and the development of overarching coordination programs. Over 2,000 persons attended a meeting last year in Anaheim to discuss Healthier Communities[1]. Greater coordination was a key topic; the pot is beginning to boil, fired by a mixture of social and economic pressures.

The theme of coordination is being addressed among national associations as well. Recently, the American Hospital Association, with the Hospital Research and Educational Trust (HRET), has published a vision entitled, *Community Care Networks* (1994), which called for collaborative networks of hospitals, physicians, other health providers, and social agencies to work in a coordinated fashion for a fixed annual payment—with their success being measured not only by overall costs but by impact on health status. In October 1994, HRET received a $6 million grant from the W. K. Kellogg Foundation to monitor and guide local community initiatives and to coordinate a concept of community benefit standards.

It is important to note that the AHA guidelines supplementing the vision stress such key concepts as: childhood immunization, mammograms, and other preventive efforts; the need to promote primary care and improve environmental conditions; and the need to control costs through an attack on root causes—for example, teenage pregnancy, lack of prenatal care, alcoholism, substance abuse, preventable

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accidents, and poor nutrition. Communities are being urged not only to coordinate health programs but to *broaden* their definition of health as well. What has prompted establishment of such guidelines among AHA leaders remains speculative, but one suspects that the realization has grown that a broader definition of health that includes new local initiatives is the most effective route to value, and for some, only on such a path can hospitals and allied health institutions lay legitimate claim to being accountable and thus deserving of special tax status.

Employers and health plans are also beginning to look at performance indicators from an increasingly broad-based community perspective. The guidelines of the Health Employers Data Information Set (HEDIS) seek to apply preventive and patient satisfaction–oriented performance criteria when comparing health plans. Health plans themselves are becoming increasingly focused on these issues as they seek accreditation through the National Committee on Quality Assurance.

The Jury Is Still Out, but the Reasons for Coordination Are Compelling

It is true that we have little evidence yet regarding how local initiatives that are built on a concept of coordination have succeeded in improving access, reducing fragmentation, improving quality of care, or moderating cost increases. We appear embarked on a new cycle of social medicine, but the jury is still out. On the other hand, before opting one way or another, we should remind ourselves that a significant amount of medicine is practiced without outcome validation, and some of it seems to do some good.

It is interesting to speculate on how community programs will fit the new perspectives in Washington and among several states. Involving cooperation as well as competition, the programs at first appear bureaucratic or even faintly socialistic, but because they are local versus national and consumer-driven versus command- or regulation-oriented, they are at the same time conservative. The proof will lie in how well provocative visions are implemented across the country, and the test of success in today's political climate is likely to be pragmatic.

Certainly, the rationale for greater community initiative is compelling given the problems we still face, even after considerable reform among health systems has taken place, driven by competitive forces. But, in my view, the rationale extends beyond the fact that we have problems to solve, many of which are well pointed out in Sigmond's article. There are underlying pressures—for example, political and market forces that inevitably leave voids that must be filled at the local level in health and other services. We do not live in a unified country; there is wide diversity among states and communities; general rules and regulations must be adapted locally for good results. It is at the local and neighborhood levels that a broader concept of health, involving social as well as clinical factors, takes on meaning. At the local level, it is easier to clarify the relative responsibilities of individuals, institutions, and communities and to make difficult priority decisions. In addition, we should remind ourselves that a major source of financing health care is still out-of-pocket, and both payers and consumers need better local information—the type of information not always volunteered by competitors—in which they can have confidence in making health care decisions.

Practical Suggestions on How to Proceed

Sigmond performs a very useful function in providing us with many useful precepts and working rules in implementing a community vision. A few deserve emphasis:

- At the community level, the coordinating function should be organized separate from

the control function and rely primarily on education rather than authority.
- Expressing community needs in terms of specific resources—for example, CON approvals—rather than in terms of mission-driven, coordinated systems rooted in community problems is unproductive.
- A problem-solving basis mechanism should be developed to achieve a coordinated vision on an incremental basis, keeping in mind that opportunities are much broader than simply overcoming duplication of resources.
- Such agencies should, for example, articulate a vision of the future community health care system, maintain a creditable information system, develop an analytic capacity, develop an adequate staff, provide technical assistance, propose community initiatives, develop community partnership standards, and communicate results aggressively with all segments of the community.
- Adequate funding for a five-year venture is desirable, if not essential.
- Governance and management should have reasonable independence.

Thus, we have the image of a force that works quietly and professionally among vested interests to effect better focus and to overcome unproductive, self-serving overlap and redundancy, and leads the way in filling gaps in current programs. Given the variation among local settings—such as in provider traditions, distribution and types of employers, leadership, per capita income, and population concentration—one has to be careful not to view any of the above points as immutable. How precisely local efforts are paid for or organized will vary. As long as reasonable results are achieved, there is no need for either uniformity or orthodoxy.

The Need to Face Obstacles Openly and Honestly

In his article, Sigmond is not unmindful of the obstacles that confront most new community agencies. He cites antitrust considerations, the entrenched interests of accreditation, licensing, service, educational, and others in both the public and private sectors. He mentions the false expectations (the quick fix) that are often imposed on a new agency. He feels that these obstacles must and can be overcome through "fairly well-known processes of community organization and mobilization that involve all elements of the community." He goes on to stress the importance of realigning financial incentives, so that they are linked better with community benefit, using a commitment to community rating as a prime (and excellent) example. As a further obstacle, Sigmond asserts that "there currently are no outstanding models and little consensus as to how to proceed." Although there is truth in this statement, it should be added that consensus is growing on how to proceed as persons across the country begin to share experiences.

As we address the issue of coordination in today's environment, it cannot be stated too strongly that *if coordination is ever to work at the community level, it is essential that the nature of the obstacles to be overcome be honestly and openly addressed and dealt with.* Change takes place best with a candid recognition of problems that exist, and furthermore, recognition is often the surest way to correction. Certainly, good intentions are not enough, and one sees in many rediscoveries—for example, the need for coordination—an intoxication that can backfire into a greater focus on the medium rather than the message. In this context, I should like to add a few observations.

- Leadership is very hard to find and instill in many communities, but it is essential to identify and engage a few community-oriented, risk-friendly, well-respected individuals. If these persons have been at all proactive, some conflict of interest is inevitable, but declare it and then "get on with it." Often outside experts are needed to spark action and develop momentum. It is

interesting to speculate on why fewer community leaders are stepping forward these days in the health field. Perhaps, it is due to the greater diversity and complexity of health services and greater difficulty in defining the issues. With a better informed and educated public, station in life or charisma may count for less. Or it may also be due to the fact that traditional figures such as physicians or those of inherited wealth have fallen off their pedestals. Possibly, we are experiencing a lessening of community values as the health field becomes more product-oriented and commercial. Or worse, we may be losing our sense of civic engagement or mutual independence. Whatever it is, it means that we have to be better prepared when launching local initiatives.

- The complexity involved in harmonizing often competitive forces and cultures in the community's interest demands rare management and governance skills. We simply do not have enough persons with these skills to go around; to move forward we need to do the best we can, but we also need to start to train these skills.
- It is tempting to lapse into elitism when selecting persons for governance responsibilities or when designing specific strategies or programs. To do so today requires that a wide range of community skills and perspectives be involved. For example, community agency boards should have one-third consumer, one-third provider, and one-third buyer representation, and these boards should then make ample use of task forces and neighborhood units. The concept is more consistent with an ecosystem than a hierarchy. How many have the insight and patience to avoid short cuts?
- Sufficient capital to stay the course is highly desirable; such support is there among foundations, employers, providers, and others, but it must be unlocked by a well-drawn strategic work plan and sold by strong leadership. The development of a good information system *alone* will cost a significant amount.
- Boundaries are a very practical matter—where does a community begin and end? Some communities are too small and too remote to take many initiatives—who is their partner? Communities overlap—who takes the lead? Many of us live near state borders where government and market boundaries do not coincide, introducing new complexities. In a large urban sprawl, how does one take a manageable bite? Is one's loyalty at home or at work? The focus must be on "natural," not necessarily traditional, markets.
- Just as authority is useful in a command hierarchy, reliable facts are essential in a matrix environment reliant on goals, objectives, and persuasion. Such facts regarding cost, use, or quality are not readily available in most local communities, and the game gets to be primitive too often as a result. Getting useful information should be a high-priority initiative. Too many assume information is available but find it is either absent or useful only for other purposes.
- How community agencies are structured is important, but as pointed out in Sigmond's article, the playing field must be reasonably level; community rating was offered as an example of what tools are needed. Other possible examples include some understanding of a basic benefit structure among employers, establishment of primary care as the focal point for convenient initial access to care and coordination of care, establishment of monitoring methodologies, and development of performance specifications. We are learning that a minimum number of changes are necessary—for example, to restructure or improve the fact base without changing perverse incentives may be a waste of time.
- Under the best of circumstances, widespread ownership of a vision even when supported by a work plan means hard work, perseverance, and keeping one's eye on major community objectives rather than always reacting to territorial interests. A sense of

pace is needed that is uncharacteristic of socially ambitious volunteers.
- Clearly some communities are so troubled that other priorities deserve prior attention. Bad timing is always a hazard; waiting to start is sometimes the best strategy.
- Current speculation about what reform we can expect from the 1995–1996 Congress suggests only modest increments of change. It will not be enough to correct only a few structural market problems, although it may help. While it provides a greater incentive for coordination among communities, at the same time, it will make coordination more difficult.

The obstacles are sufficiently daunting to discourage many communities, even though several have taken the initiative across the country. Some find themselves without the skills needed, even when the overall desire to do something is strong. Lamentably, persons who have the best backgrounds, such as health system executives, are more apt to be part of the problem rather than the solution by yielding to internal pressures and tensions. Thus, some outside help becomes almost inevitable.

Given the obstacles, it is important to stop and remind ourselves, as Sigmond has, that authoritative approaches to coordination have not worked well, for instance, the Hill-Burton Act and the National Health Planning and Resource Development Act, P.L. 93-641. Both the market and regulation work well up to a point, but not beyond it; another force is always needed. A case in point involves emerging health systems: Even with competitive local markets and with authority vested in holding companies, too many systems have not fulfilled their potential (e.g., reduced overhead, cutback on excess beds, and overlapping programs), failed to add efficiency to operations, or even improve contributions to the underserved.

Thus, coordination is more than the challenge of orchestrating the present system, but it's changing it. A major challenge is to demonstrate that this can be done with broad subscription to common goals, education, and a strong fact base short of ownership.

The Bottom Line

At the bottom line, coordination efforts are needed because there are no good alternatives, no matter what turn reform takes. In this context, it is important to remember that we should not be talking about regulation, competition, *or* coordination; rather we should be talking about how the ingredients of competition or regulation can be structured to remain, on an ongoing basis, reasonably aligned with the overall community good. In the last analysis, the potential of coordination programs rests on some measure of effective competition and on enlightened regulation that lightens the burden, for example, of excess manpower and excess technology. The key is in the balance of these forces, none of which can do the job alone. Nor should we pretend that coordination is ever easy. It is at its best when focused on a selective number of high leverage points and when it recognizes that some overlap and fragmentation is, inherently, creative; when it is friendly and supportive, not pietistic or self-righteous. Coordination is in danger when self-realization—as opposed to community-realization—becomes our only undisputed value.

One small final point: I have reservations about the article's title, "Back to the Future," for two reasons. First, lack of progress since the CCMC recommendations were made can be cited as a reason community coordination agencies will not or cannot work (whereas the differences in the environment in the '20s compared to the '90s might well be the key, and communities are now ripe). Second, local initiatives should start with a vision, and visions are best formulated not by looking in the rearview mirror, but by looking ahead and asking openly and honestly what can be done, creatively, with a clean slate. This perspective,

formulated by today's citizens, can lead to reform of lasting value and reform at the level where most health services are rendered and paid for—where we live.

Note

1. The *1994 Health Communities Summit* was held in Anaheim, California, 30 April–3 May 1994 and was sponsored by The Healthcare Forum.

Reference

Hospital Research and Educational Trust. 1994. *The Community Care Network Demonstration Project*. Chicago: American Hospital Association.

PHILIP A. NEWBOLD

Building Healthy Communities

Sigmond eloquently detailed in his article his vision for the future of American health care. And while the specific details of community care networks may vary by community—as well as the local and national experiences that lead to their creation—Sigmond is exactly correct in his assertion that community coordination of health care services is the solution to what has become a very competitive, complex health industry.

Imagine the history of health care in America plotted on a trend chart. You can start the clock running at the emergence of what we consider to be the modern-day hospital. You will later see the advent of today's insurance models, regulatory systems, and government involvement. And at the far right of the graph, you will see the recent flutter of activity as managed care and other new ideas begin to influence the course of health care in our country.

Health care's history does not fit on a one-dimensional time line. Its history is one of sharp upward swings (advancements) and long plateaus (the new status quo) as each new program, each new medical or economic revelation pushes the complexity of our health care system up a notch. As the complexity has grown, so have both the demands on our system and our understanding of its capabilities. As Sigmond indicates, we are now at the foothill of another upward thrust in the evolution of American health care. It may be a turbulent climb, but the next plateau holds his vision of a truly community-based, collaborative health care delivery system that, for the first time, will direct resources at the very points at which health is created.

Most hospitals and health systems seem to be caught in a rather awkward position as they try to navigate between two very conflicting realities. On the one hand, we seem to be caught up in a "middle game," which is marked by a rapidly growing investment in developing an integrated delivery system (IDS) based on a heavy-competition model. Huge investments are going toward acquisitions of physician practices, development of risk-bearing managed care products, and PHO arrangements with our medical staffs. Concurrently, we are keeping the other eye on the "end game," which is a more collaborative, cooperative approach to developing healthy communities and being more accountable for the health status of a defined population. As we navigate between these two points, it places great stress on organizations, boards, and medical staff leadership to create a vision for the future and develop successful delivery models.

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The Future Four

There are basically four new premises that underpin the movement toward developing healthy communities and new models of care for those we serve. The first premise is that *health care cannot be reformed from the top; it can only be reformed at the grassroots,* or the bottom part of our health care system. "One size fits all" solutions from Washington, DC, or our state capitols seldom take into account the complexity, diversity, and unique characteristics of our communities. In order to be successful, grassroots models with empowering initiatives at the local community level are the only models that will be sustainable in the future. Unfortunately, these are models with which we have little experience to date. Doctors and acute care hospitals do not create health. Rather, health is created and nurtured (or abused) by our home environment, by our neighborhoods, by the places we spend our time, and by the decisions each of us makes every day for ourselves. Therefore, to succeed in creating greater health and improving the quality of life, we must have greater impact and leverage resources at these crucial points in our communities, families, and neighborhoods that largely determine our health status.

Much of the central planning in Washington and the state capitols across the country cannot begin to address health status with the precision of a true grassroots effort, which is many times more responsive to local needs and the interests of people who make local health care decisions on a daily basis.

The second premise is that *we need to develop new infrastructures in our communities and a new knowledge base if we are to move away from this acute care "sickness model" to a new model that is based on wellness, health, and individual accountability.* That infrastructure is largely built around educating people about the choices they make that lead to healthier lifestyles and a greater degree of health for themselves and their families. From there, we must develop new community resources, which often involves a redeployment of existing services away from acute care into prevention and primary care. And finally, we must develop grassroots, citizen-driven coalitions that can have a greater impact on a community's overall health status than hospitals and physicians do under the current sickness model. Our encounter with patients is usually long after the disease process began. A viable health care system in the future must emphasize more of a preventative approach, as opposed to a curative one.

At Memorial, we have built infrastructures by using "community plunges" to educate our board, community leadership, and medical staff on the problems facing people in our communities, as well as to identify the gaps in services and hear firsthand the experiences of people who need health services. These experiences become the basis for a new knowledge base of what exactly the needs in a community are and provide a face-to-face set of experiential learning that often results in board and physician leadership adopting a more aggressive, more expansive outreach approach to solving community health problems. Additionally, our board has adopted a "tithing" policy, which reserves 10 percent of Memorial's prior year's earnings for community outreach efforts oriented toward prevention strategies. It is particularly important today, in an environment of cost-cutting and downsizing, that resources are set aside and protected in order to develop long-term solutions.

The third premise is that *every school, church, synagogue, place of worship, neighborhood, recreation center, and work site is a potential delivery site for prevention and wellness services in the future.* No longer can we expect citizens to come to acute care settings to improve their health status; rather, our hospital and health service organizations need to work cooperatively and collaboratively with community resources (such as schools, churches, and businesses) to create health in the everyday choices that affect people directly. This means that we have to look at resources in our

community differently than we have looked at them in the past. Again, the grassroots efforts of citizens in coalitions, neighborhood groups, congregations, parishes, and work groups can have a greater impact on long-term improvement of health status than can acute care providers in the current sickness model. We need to leverage these resources out in the community and build coalitions not around providers, but around citizen groups that are empowered to identify unmet needs and improve the delivery of preventive health care as well as screening, detection, and early intervention services in our neighborhoods and our work sites. As Leland Kaiser has often commented, there are enough resources to take care of every citizen if only those resources were redeployed in more rational ways and built around the notions of prevention and wellness instead of acute care and curative models of care. In a sense, we will be developing "virtual" organizations to deliver health care services in the future, which is in stark contrast to the notion of a top-down control type of organization characteristic of modern-day bricks and mortar corporations and acute care systems.

At Memorial, we have launched a number of outreach efforts involving collaborative partnerships with schools, churches, synagogues, and neighborhoods. Our partnerships with Studebaker School and Harrison School connect Memorial with two inner-city elementary schools and provide the foundation for a nontraditional point of access to a population. Our involvement has grown from sponsoring health fairs to sponsoring meaningful intervention programs, among them special parental counseling classes that target behaviors that put the family's health status at risk. This is a starting point, but it has opened the door to endless possibilities and new partnerships within our city's school system.

Similarly, we have developed a strong partnership with places of worship in our community. The Congregational Nurse Program provides congregations in our region with a nurse whose role is to oversee the health status of his or her congregation. The nurse, who is typically a member of the congregation he or she serves, is paid a part-time salary and benefits that are made possible by Memorial's tithing policy. Over the period of five years, the individual congregations will gradually take on more of the salary responsibilities, although Memorial will continue to pay for the nurses' benefits. This program represents yet another new venue for health care delivery. These nurses are specially trained to be responsive to not only the physical needs of their congregation members, but the psychological and social needs as well. They work to make sure congregation members get the services they need. In some cases, their role extends into the neighborhood where the church or synagogue is located.

The final premise is that *new models are needed so that we can derive an opportunity to apply for waivers from the existing rules and regulations from ERISA (the Employee Retirement Income Security Act), Medicare/ Medicaid, and antitrust that will help us eventually develop community-sponsored health insurance plans.* Currently, we do not have enough of the new models to take to lobbyists or elected officials that demonstrate improved health status and delivery of needed services at the local community level. If we are able to develop some new models that are built around the principles of prevention, primary care, managed care, and wellness, then we will have an opportunity at the grassroots level to seek waivers or exemptions from many of the top-down, central, bureaucratic approaches to health insurance and central health planning that presently devour 25 percent of the dollars spent on health care in this country.

One such model involving Memorial is the Community Health Partnership, a program that combines the elements of managed care and prevention to provide health care coverage to people in transition. These may be people who are training for a job but are still in school and cannot afford insurance. Or it may be people

who are working and cannot afford their employer's health plan. Basically, the Community Health Partnership provides Medicaid-ineligible participants with up to $10,000 of health care coverage for two years. Participants are enrolled in the Partners Health Plan and receive care in the same manner as anyone else in the HMO. A third collaborating agency, Family and Children's Services, provides a case management component that works with participants to tackle the issues that have kept them from securing more permanent health care coverage. Although launched less than a year ago, there already have been some success stories of individuals finding better jobs or working through other barriers to adequate health insurance. Approaches like the Community Health Partnership, Congregational Nurse Program, and school partnerships represent new ways of health care delivery. They are nontraditional, they are grassroots, and they are examples of what can happen at the neighborhood level when people and organizations collaborate for the benefit of the greater community.

Conclusions

For many communities, the vision for the future will be one in which residents reclaim a sense of community that is based in the neighborhood and in the family unit. This new vision is one that requires us to have a great deal more personal accountability in the choices we make concerning ourselves and our families. It is one that is both empowering and extremely complex and time-consuming, one that is based on the principles of collaboration and cooperation. New models of care and new pilot experiments will be necessary if we are to develop the kind of system that is responsive to local needs and yet has elements that are replicable so that other communities can learn and adapt them to their own models. Only in this way will we be able to develop the kinds of grassroots organizations and models of care that are sustainable for the long term and will begin to move away from the quick-fix sickness model toward one based on wellness, prevention, and long-term improvement in the quality of life. These new models require leadership with a strong sense of community, human values, and spirituality. Never has there been a more compelling time to develop bold new community-responsive approaches than today, when our nation is searching for long-term solutions to health care problems.

DREW ALTMAN

The Market and Regulation: Where Community Forces Fit

Last year's health reform debate showed us that there is widespread agreement about the problems in our health care system, but very little agreement about solutions. If you followed the national debate, you would have concluded that there are basically two schools of thought about how to reform our health care system. Marketeers believe that we should leave the job mainly to the private sector and build a better functioning health care marketplace. Regulators, on the other hand, believe that only government intervention and government cash can solve our health system's biggest problems. Crossing between these two camps are a large number of very reasonable people who see merit in aspects of both approaches and have been working to try and meld them together by figuring out what the proper role of government is, and what should be left to the marketplace instead.

What is fascinating, provocative, and entirely admirable about Bob Sigmond's article is that he reminds us that there has been and apparently still continues to be a third school, one that believes that the answer lies not so much with government or the marketplace, but rather in planned attempts by community leaders at the local level to better coordinate and organize care and to make health rather than medical services our top priority. Certainly big problems that take tens of billions of dollars to solve cannot be solved by community initiative—like the problem of the 40 million uninsured. But the values embodied in Sigmond's vision are absolutely the right ones for our health system.

The fact is that almost all of our efforts to coordinate health services at the community level—however imperfectly covered—have yielded either modest or disappointing results. Some of these have been inspired by government. For example, the kinds of community-based solutions and planning Sigmond advocates were also at the core of the health planning program of the 1970s. How many of you remember HSAs (health systems agencies), SHPDAs (state health planning and development agencies), and SHCCs (statewide health coordinating councils), the state and local health planning organizations charged with rationalizing health services at the local level? Not many, I suspect, because the idea, while well motivated, did not work. Other efforts have been inspired by the private sector. Sigmond himself led perhaps the largest attempt at community-based leadership and planning, a program called The Community Programs for Affordable Health Care, which was funded by the Robert Wood Johnson

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Foundation. I was the officer at that Foundation responsible for the program at the time. I greatly admired what the program was trying to do, but it failed. It is extremely difficult—if not impossible—for hospitals, doctors, businesses, government agencies, and just regular people in the community to work together when their interests flat out conflict. The closure of a hospital or hospital wing can be a great victory for a community health planner and a catastrophe for that hospital, its board and staff, and neighboring community. We learned in that program that communities have a desire for medical self-sufficiency that almost always puts them at odds with efforts to "coordinate" or "plan"—hence the need for external forces, be they the market or the government.

Sigmond suggests that we keep trying for a coordinating entity at the community level that can work better than these and other past attempts. But history teaches that "coordination" without control of resources is a thankless task. Admonition and philanthropic instinct will go only so far in a trillion dollar health care sytem where leaders of health care organizations are rewarded according to the revenues they bring in and not the community health problems they solve.

However, while it is probably wrong to believe that our health care system can be rationalized by some new kind of community entity, in a deeper sense, Sigmond is absolutely right that what ultimately happens in health care will be decided by people—if not coordinating agencies—at the community level.

In the end, neither government-based nor marked-based reforms can make it without public support. We learned the hard way in 1994 that it is all too easy to defeat governmental reform when cynicism about government is on the rise, new taxes and mandates are so difficult to sell, and people are at least reasonably satisfied with their medical care. It was really the American people and not "Harry and Louise" and the organized interests that rendered the verdict that health reform would have to proceed in bite-sized chunks, rather than in one sweeping package. Health reformers ignore the views and needs of average people in average communities at their peril.

Ultimately, people will also pass judgment on the profound changes occurring in the health care marketplace. Our health care system is in the midst of sweeping and unprecedented change. Insurers and providers are transforming themselves and their relationships with each other as the health care system is increasingly being organized and corporatized. And in some areas, including parts of California, the costs of health care actually seem to be dropping, at least for some payers.

Some hail this development as the dawn of a new era of more effective cost control, accountability for quality, and empowerment of consumers. But others fear the coming of a business orientation to health care and worry that people will not get the care they need in the new system, particularly the poor, minorities, the uninsured, the very sick, and those with chronic illness. Ultimately, local community by local community, a judgment is going to be made about what is good and bad about the changes occurring in the health care marketplace. Do we want the nonprofit orientation of our health care system replaced by an increasingly concentrated for-profit sector? Should managed care plans be able to pick and choose only the doctors they feel provide the most cost-effective care, or should all qualified doctors be assured of the right to practice in the plans of their choice? Should we require that employers offer their employees multiple choices, and should there always be a fee-for-service choice? Should big city public hospitals, community clinics, and other nonprofits be afforded special protections so they won't lose out in the market shuffle? Should managed care plans be required to take their fair share of the poor, the uninsured, and the higher-cost chronically ill? The questions are big ones that we have only barely begun to confront.

I doubt that we will be able to confront these issues through some new kind of community planning mechanism or organization. Indeed, the entire health care system is going

in just the opposite direction—corporatized, market-oriented, and profit-driven. What *is* clear, however, is that solutions need to be tailored to local circumstances and needs at the community level, and it is here that community forces can have their biggest impact. They cannot replace government or the market as the driving forces in our health care system, but they can affect how those forces play out, community by community, across America.

The real challenge we face is how to make the changing marketplace work for people and in the public interest. And in meeting that challenge, there will be no one savior; government, media watchdogs, community and health care leaders, and average people all have a role to play. It is in this sense that Sigmond is right: We as a broader "community" will ultimately determine the future shape of our health care system.

REPLY

In writing the article for *Frontiers*, I advised health care managers "to prepare for the inevitable drastic reduction in health care resources that will be imposed one way or another, sooner rather than later, from outside the community." I urged professional health service managers to speak out now on what they know to be true: "that with community control, support, and patience, they can overcome the fragmentation of the health care system and guarantee access to decent health care for everyone at much less cost." Little did I dream that even before publication, leading politicians would be echoing my admonition to the health care establishment to "do more with less," as Congress prepares for massive cutbacks in Medicare and Medicaid funding.

Reviewing the three commentaries on the article, I was impressed that none made any reference to my dour predication or bold recommendation. Taking a longer historical point of view, none of my critics made any direct reference to the gathering financial storm clouds. While approaching the article from quite different perspectives, however, all three do support the notion of community coordination: Newbold said, "community coordination . . . is the solution"; McNerney said, "community coordination is a key missing ingredient . . . . there are no good alternatives"; and Altman said, "solutions need to be tailored to local circumstances" and "what ultimately happens . . . will be decided by people . . . at the community level."

Each critic provides his own rationale for commitment to community initiatives. All three are cautious about significant short-term benefits. Altman is the most skeptical. McNerney counsels dealing systematically with the obstacles to be overcome before getting started. Newbold's approach emphasizes incremental "community plunges" to educate the leadership and to provide firsthand experiences that can result in ever more expansive approaches to solving community health problems. Their different perspectives provide an opportunity to underline, clarify, and elaborate a few key points.

Coordination entity. The major difference among my critics relates to the proposal for some type of entity committed to a more coordinated system in every community. Of the four alternatives in my article—an independent organization, an existing organization, a community care network or CCN, and finally, "virtual reality"—only the first and last are supported. Newbold seems to be closest to my own view that virtual reality is the best initial approach in complex communities like South Bend, Indiana, with two or more nascent CCNs. Given Altman's skepticism, the virtual reality approach seems to be the only one he could

possibly support. By contrast, McNerney focuses sharply on an independent coordinating agency. While emphasizing the daunting obstacles, he also provides a wealth of wisdom on methods of overcoming them, based on his wide experience, most recently in Calhoun County, Michigan.

As correctly pointed out by the critics, "history teaches that 'coordination' without control of resources is a thankless task" (Altman) but also that "authoritative approaches to coordination have not worked well" (McNerney) either. The only successes in this country so far have been early versions of the virtual reality approach, based on leadership of very pragmatic visionaries who understand how control works in a community context. In Rochester, New York, for example, there was no single entity that took charge of the common vision of Marion Folsom at Eastman Kodak, David Stewart at Blue Cross, and others. As described in my article, these leaders turned their shared vision into reality by their skill in realigning incentives of the specific organizations they controlled or influenced, blending narrow self-interest and enlightened community interest among entrepreneurial, regulatory, and tax-exempt entities. As with modern virtual reality technology, there was no "real" reality that one could actually touch, see, or struggle against. They succeeded because their vision and commitment and actions helped everyone to see more clearly how to change their own behavior—not only in the community interest but more directly in their own interests. The future involves many other similar exciting efforts to turn the CCN vision into virtual reality. Newbold is already on the right track with his approach to "virtual organizations." Many other health services managers are moving in the same direction all over the country, as McNerney points out, with leadership and support from the American Hospital Association, the Catholic Health Association, The Healthcare Forum, and the W. K. Kellogg Foundation, to mention only a few.

Eventually, in communities that evolve into a single organizational reflection of the CCN vision, the coordination entity clearly belongs within that organization. Most complex communities evolving toward two or more fully developed, competing CCNs will probably require an independent entity to achieve optimum results. The important point is that coordination within and between organizations is what counts. A coordination entity can facilitate and help to accelerate these processes, but it is not required, especially at the beginning.

The interplay of marketplace, regulatory and community forces. Another important perspective reflected in the three commentaries involves the relationship among marketplace, regulatory, and community forces. McNerney's formulation is right on target, and so is Altman when he writes that community forces "cannot replace government or the market as the driving forces in our health care system, but they can affect how these forces play out, community by community, across America." Of course, Altman is mistaken when he suggests that we believe that "the answer lies not so much with government or marketplace, but rather in planned attempts by community leaders at the local level to better coordinate and organize care." Those of us who subscribe to the concept of community coordination efforts believe that it is the *missing* element—not the most important element—in successfully solving our health care problems. We are really a part of the school that Altman identifies as trying to meld the initiatives of marketeers and regulators. The only feasible way to do that, to my knowledge, is through community initiatives, getting things done through community action, as contrasted with simply planning. With more appropriate incentives built into various marketplace transactions and regulatory processes, marketeers and regulators can strongly support—and interfere less with—coordinated community initiatives that will serve their purposes. But such issues as universal entitlement and overall allocation of national

resources to the health field require initiatives well beyond the community's grasp.

Community health care reform: short-term, long-term, and the hereafter. Finally, the most important difference reflected in the comments of the three critics involves the time frame of their perspectives on health care reform. Both McNerney and Newbold are visionaries, leaning heavily on the CCN vision of the American Hospital Association in their approach to health care reform. But both of them view the CCN vision from the different perspectives of their current role in the health care system. As one of the very best academics ever, McNerney sees the current "system" as badly flawed and thinks in terms of careful preparation for major change. That is why he calls for better trained executives and emphasizes the importance of recognizing and dealing in advance with the overwhelming obstacles to success. By contrast, Newbold is very much like other executives who have played such an important role in the history of health care reform in this country; he focuses on moving ahead right now with incremental problem-solving approaches in which his organization can play a leadership role, initiatives that demonstrate and confirm the practical value of the CCN vision. By contrast with both of them, Altman is not yet ready to embrace any specific vision of the future but is convinced that we all, as a community, will somehow ultimately shape the marketplace to work for people in the public interest sometime in the hereafter.

With respect to time frame, I share Newbold's commitment to both the long-run CCN vision and to starting with stepped up community involvement in incremental, doable problem-solving that illustrates the value of a new mindset. This would appear to be the best way to unlock the creative energies of consumers, professionals, entrepreneurs, and public servants in our field that will enable us to do much more with much less.

Admittedly, it isn't easy to focus on healthier communities beyond critical care and the latest technological advances, on competitive health care results beyond the marketplace, on accountability beyond the bottom line. This is not a quick fix that will bring rapid, measurable results. But collaborating with competitors on incremental steps toward the community care network vision is the real frontier of health services management in the new reform environment. Exploring this frontier, managers can not only make a contribution to our troubled society and take pride in their role in these achievements, they can also renew their commitment to their chosen profession, and have fun in the process.

—R. M. S.

To Our Readers

Dear Editor:

Having had a long-time interest in governance of health care organizations, I was pleased to see the Spring 1995 issue devoted to "The Governance Challenge." I read it from the front cover to the last page and came away with an uneasy feeling about the contents. The premise of the Spring issue's focus is on integrated health care systems as a way of reinforcing the traditional social values associated with what has taken place in health care over the last several decades. To my way of thinking, it appears to turn the clock back to earlier times and to ignore the realities taking place on a daily basis. The development of integrated health care systems is a direct response to changing economic conditions where providers are scrambling for survival. As competition among providers intensifies, the community mission declines. It would be wonderful if this were not true, but when economic competition becomes the name of the game, what was important gives way to new realities.

Clearly, the development of integrated health care systems is a reactive response to what is happening. Developing larger organizations that are both vertically and horizontally integrated requires increased capitalization. Simply relying on debt instruments for capitalization is no longer viable. Making fixed loan repayments on a monthly schedule is no way to expand. What are needed are both debt and equity sources of funds for rapid expansion. Main Street has been replaced with Wall Street, although many of my professional colleagues are loathe to admit this is the case.

Because of the need for equity funds to fuel expansions, the future of integrated systems lies in the for-profit sector. Furthermore, since physicians will be playing an increasing role in integrated systems, they will insist on these new organizations being for-profit, as they are in their own practices. As for-profit entities, investors will be concerned with a return on their investment; this will force governing boards to choose between dividends and community mission. The loser will be the community mission.

As for-profit integrated health care systems gain strength, the role of the nonprofit component, the hospital, will no longer be a major force. The concern of the system in a managed care environment is with the revenue stream of dollars and not with the concerns of the hospital, which will have little impact on the decisions that are made to capture managed care revenue.

The only set of circumstances that fosters community mission is where the managed care plan, hospital, primary care physicians, and specialists are all under the same organizational umbrella. However, if hospitals and physicians simply are linked by contract to the managed care plan, they are compelled to focus on economic factors. When the choice is between financial survival and community mission, keeping the organization going will dominate all other interests.

Under the circumstances I have just described, the controlling factors are most likely to be managerial decisions rather than board decisions. Knowledgeable health care executives and physician leaders will be making decisions in the administrative suites of integrated delivery systems, rather than in boardrooms. In other words, in an intensely competitive economic environment the major decisions are operational and will be made by those with the needed hands-on experience.

Those who believe nonprofit integrated health care delivery systems are the wave of the future need to appreciate what is going on in other segments of health care. Many Blue Cross plans are moving as rapidly as possible to become for-profit corporations using equity monies to capture and control the marketplace. Other for-profit corporations are using equity sources to buy large numbers of physician practices.

Forgotten for the moment are the social values that have been important to the development of health care in this country. Clinging to community mission at a time when "mom and pop" health care organizations are being replaced with for-profit integrated systems seems to me to be a way to ensure failure. Once the present "feeding frenzy" has passed, it will be possible to reassert community mission, but it will come about only when a managed care plan and the providers are in the same organizational structure. Even though it will be in a for-profit form, the leadership of these organizations will recognize that having a community mission is good for business, as well as in the best interests of the community.

Sincerely,
Richard L. Johnson, FACHE
Chair, TriBrook
Westmont, IL