LEARNING FROM THE GHOST OF HEALTHCARE PAST

INPATIENT BEDS LIE EMPTY AS OCCUPANCY CONTINUES TO DROP. *Revenues are falling precipitously. Resources are scarce and growing scarcer, and the pressures to do more with less escalate daily.*

The healthcare field is in crisis, and in response, it is developing new strategies for managing the financial crunch. Reformers suggest that "much waste can be eliminated in our present system" by coordinating the efforts of different agencies. And there is a movement toward new forms of financing.

The year is 1932, and the crisis healthcare is facing was brought on by the Great Depression. Clearly, neither today's problems nor many of today's attempts to solve them are unique to our time.

Historically, a reduced income stream has been a powerful incentive for fundamental healthcare reform, a stronger health system, and healthier communities.

Currently, the health establishment is struggling with inevitable reductions in the rate of increase in Medicare and Medicaid spending, as well as efforts of Fortune 500 companies to contain increases in their health insurance premiums. Shortly, the emphasis will shift from reduction in the rate of increase to absolute reduction in available dollars.

For many providers, the very idea of less money is unimaginable and unacceptable. With the population aging and increasing at the same time, with continuing advances in medical science and technology, and with inflation not completely checked, they feel that the total amount of money can't possibly be cut.

But it has happened before. The field as a whole has in fact faced a real reduction in resources during more than one critical period in the past. And it managed to survive these experiences with no measurable adverse effect on the nation's health status.

We can never go back to the past, but we *can* draw on historical perspective to help us deal with the financial crunch that lies ahead. One of the lessons history teaches us is that the health services field is not an independent variable; it is dependent on what is going on politically and economically in the nation and the world. A review of the history of the field indicates that the kinds of political and economic imperatives that we face at the present time almost inevitably will lead to absolute reduction in available resources. At the same time, history has some good news for those concerned about impending cutbacks. In the past, a reduced income stream has been a powerful incentive for fundamental healthcare reform, a stronger health system, and healthier communities.

So let us call on the ghost of healthcare past and see what it can teach us about the present—and the future.

Two crisis points

There were two previous periods during this century when healthcare faced major cutbacks. In both cases, a seemingly impossible situation was largely resolved through greater integration within the health establishment. Both occurred during simpler times, but there were no easy solutions even then.

The first crisis occurred during the early Thirties, as the Depression reached its height. There was no federal funding of community health services outside of the Indian reservations, and there were virtually no Blue Cross or other health insurance plans throughout the nation.

Demand for hospital services had been increasing at an astounding rate during the previous two decades as hospitals upgraded themselves from places for the least fortunate in society to become the preferred location for physicians to serve their private patients. By 1928, approximately 80 percent of inpatients were able to pay for some or all of their care, and hospital construction was at an all-time high.

Following the market crash in 1929 and the subsequent collapse of the economy, few patients could afford hospital care. Occupancy dropped and income fell off precipitously, as general consumer expenditures declined 37 percent between 1929 and 1933. Physicians who could not pay their office rent moved their practices into vacant space in the hospitals.

Despite many payless paydays and other crises, the health system survived. Communities rallied to support the struggling hospitals and physicians, and health indices throughout the country were not adversely affected. Declines in the number of hospitals and beds were each less than 15 percent, except in the proprietary category, in which 43 percent of all the hospitals disappeared entirely. No major hospital closed its doors during the Depression.

Among the most significant innovations of this deeply distressed period was the founding of insurance plans, which charged the public for hospital service on the basis of capitation instead of fee-for-service. Individual hospitals showed the way, but within a few years, in almost every community, the hospitals, and subsequently the physicians, joined these programs. Subscribers paid the same amount for covered services, irrespective of their health status or whether they utilized high-cost or low-cost providers.

Strong initial opposition from organized medicine at the national level and from some local providers was overcome as the value of affordable Blue Cross and Blue Shield community premiums became evident. The typical Blue Cross monthly premium was 50 cents for individuals and a dollar for families. These premiums generated a great deal more money than could be collected out-of-pocket in the depths of the Depression. As a result, the providers had great interest in keeping the premiums as low as possible to encourage more people to sign up. Within a decade, Blue Cross was the largest membership organization of any kind in the country.

A second resource crisis occurred during World War II. This time the crisis had a different focus. Half of the physicians and nurses left their communities along with the healthiest part of the population during a time when it was virtually impossible to obtain any building supplies and equipment or manpower required by the armed forces.

The pressures on those remaining on the home front to do more with less were intense. People pitched in with unselfish focus on what was best for the community as a whole. A wide variety of professional coordination initiatives kept the health establishment functioning, again with no measurable adverse effect on health status. As physicians and other providers were drawn closer together to make the most of limited resources, successful prepaid group practice plans like Kaiser were organized, based on earlier demonstrations sponsored by physicians, hospitals, business, and consumer cooperatives. Again, there was strong opposition to these early HMOs from organized medicine, but not strong enough to block all of these courageous initiatives to do better with less.

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For those who can recall these two crises, the upcoming cutbacks in federal funding and insurance revenues must seem relatively minor. As one of them told me recently, "Fortunately, there were no planning agencies or federal regulators telling us what we could or could not do or even providing guidelines for doing more with less. We were on our own, and somehow, with massive increases in volunteer service, we made it."

He was right about the situation during the Depression, but not about the period during World War II. There were significant war-time controls, as Eli Ginzberg and others who were directly involved can attest, but these relied almost entirely on voluntary community leadership for implementation and compliance. I was involved as a junior staffer with the War Labor Board in controlling wages and manpower mobility while incidentally strongly encouraging employer participation in health insurance premiums as a substitute for wage increases.

This time, the cutback in resources will be relatively less than during these

earlier periods, but the stresses will probably be greater. The economic and managerial implications are far more complex for the health establishment, now grown accustomed to seemingly unlimited resources. Fortunately, the field is in a position to take advantage of early warning signals and the lessons of the past.

What hasn't worked

What other lessons does the past offer about how to cope with healthcare costs? In contrast with the two resource crises discussed, later periods in our history have been characterized by more narrowly focused efforts to control prices rather than coordinated community efforts to reform the system.

One of these episodes, by the Nixon administration during the late Sixties, involved direct governmental price controls. The result was an explosion of delayed expenditures as soon as the artificial controls were removed.

The other, a decade later, was called the Voluntary Effort. The purpose of this coalition of provider, insurance, business, and labor organizations at the national level was to stave off threatened governmental price controls by encouraging self-discipline in pricing products in the marketplace. When the Voluntary Effort finally declared victory and closed up shop, the sharp upward trend in expenditures reappeared.

In both of these situations, which were not accompanied by fundamental

OLD IDEAS, NEW RESONANCE

WE POSSESS A WEALTH OF INFORMATION AND ideas on managing healthcare costs from the various cost commissions over the years. Almost all of these were direct descendants of the first and easily the most comprehensive: the Committee on the Costs of Medical Care (CCMC).

This Committee, supported by the major philanthropic foundations of the time, turned out 17 extraordinary studies and reports over a five-year period from 1928 to 1932. This monumental series of books contains the most comprehensive analysis of the entire health field to this day, concluding with a small volume setting forth five specific recommendations, all of which continue to be relevant. The Committee recommended that:

1. 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 high standards and the development or preservation of a personal relationship between patient and physician.

2. All basic public health services—whether provided by governmental or nongovernmental agencies—[should be extended] 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.

3. The costs of medical care should be placed on a group payment basis, through the use of insurance or taxation or both. 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.

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

5. In the field of professional education: (A) that the training of physicians give increasing emphasis to the 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 clinic administrators.

The CCMC consisted of 50 members representing the fields of medicine, public health, institutions, social sciences, special interests, and the public. The majority supported all five recommendations, but influential minority reports from the physicians and dentists differed on recommendations for group practice and group payment. Today these two recommendations (numbers 1 and 2) are no longer controversial, and in fact provide the basis for many current initiatives. By contrast, the majority and minority reports were in complete agreement with respect to the recommendation (number 3) for an explicit coordination function in every community and state. This is the only recommendation that hasn't been incorporated into common practice. And it is a notion that is hardly even discussed these days, except in a negative context. Perhaps the time has come to take a new look at this old idea.

—Robert M. Sigmond

reform of any kind, the results were temporary. The Nixon initiative appears to have given price controls in the health field a permanent bad name.

The Voluntary Effort did embolden Fortune 500 corporations and others to seek lower capitated prices in the marketplace, and that encouraged many insurance and provider organizations to develop highly competitive capitated systems in response.

Today the marketplace is the focus for health reform initiatives, both among those responsible for putting up money and among providers dependent on the money. But even the most enthusiastic supporters of the competitive marketplace approach do not anticipate that it can provide the nation with more effective health services outcomes for much less money, especially in the short run. Actual reductions can be seen for specific enrolled groups, but not for the community as a whole.

Integration: a continuing theme

To envision what would work in our present predicament, we have to turn to a fundamental but frequently neglected concept from the past. Integration of efforts, as a means for doing more with less, has been a continuing theme in the literature going back to the Twenties. The few successful and many unsuccessful documented experiences offer a whole catalog of valuable do's and don'ts.

In 1932, the Committee on the Costs of Medical Care (CCMC) recommended "coordination of medical service" as "an important function for every state and local community" (see "Wisdom from the Past"). The recommendation was strongly supported by both majority and minority representatives on the Committee, whose reports emphasized that "much waste can be eliminated in our present system by the coordination of our present agencies and methods." (This reference to "much waste" was made at a time when the health services field was absorbing less than 4 percent of the gross national product, as contrasted with the current 14 percent and rising!)

Despite many community collaborative initiatives over the years, little has been accomplished. With the emphasis on marketplace competition—a development the CCMC did not anticipate—the country seems to have been moving farther and farther away from the coordination recommendation, except to some degree within independent corporate entities. Yet with continuing fragmentation of our ever more highly specialized services, opportunities for integrated efforts are much greater today than when this recommendation was made more than 60 years ago.

Today, opportunities to do more with less by integrating methods of operation among various disciplines, often within the same organization, are as important as integration among separate agencies or organizations. Not infrequently, different healthcare disciplines are addressing aspects of the same problem from quite different perspectives—different goals, systems, measures of success, and different mindsets—with little appreciation of what else is going on.

An example is the immunization of preschool kids. The approach of the private-practice, primary-care doctor is simple, if limited. If the parent brings the child in for an office visit, the child will be immunized; children who don't come in won't be immunized. The HMO employee, charged with the care of an enrolled population, has a list of names and addresses of covered members, and attempts to contact the people on the list so that they can have their children immunized. The public health agent has no names and addresses, but works through contacts with churches, schools, and organized events to reach as many children in the community as possible. What is needed is a balanced combination of three groups—those caring for individual patients, those caring for enrolled populations, and those caring for communities—working together. But these people don't talk to one another.

Integration of the special—and quite different—methods employed by each of these groups is an obvious avenue for doing more with less in the future. But those with training and accountabilities related to these three quite distinct approaches to healthcare are frequently working at cross-purposes, rarely with an appreciation of the potential benefits of working in greater synch.

This is particularly true of the relationship between professionals who focus sharply on individuals (or even more sharply on acutely ill patients) and professionals trained to plan in terms of populations or communities—

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even when both are in the same organization. Consider, for example, the vastly different perspective of a hospital physician, whose concern begins with a patient's admission and ends with his or her discharge, and a social service worker, whose concern is with a community continuum, on what happened to that patient before admission and what will happen after discharge.

Another obvious area where cooperation could bring some relief, and not only in terms of costs, is the duplicative and frequently adversarial relations between those responsible for utilization controls within patient care and insurance frameworks—again even when both groups are employed by the same corporation.

Still another opportunity for integration of the basic subcultures or mindsets in the health services field lies in the different approaches of many specialists in contrast to those of most physicians and nurses involved in primary and long-term care. (When neurosurgeons get together, they usually don't talk about the importance of getting motorcyclists to wear safety helmets.)

Possibly of equal importance is the potential for effective integration of methods designed to exploit the two major forces in the health field today: (1) the always-stronger, self-serving interests of individuals, and (2) their weaker but ever-present, altruistic, community-serving interests, both deeply rooted in the health professions and among community leadership.

Although community collaboration and marketplace competition are often seen as entirely incompatible, there are many exciting opportunities for effective collaboration to benefit both entre-

preneurs and communities while doing [illegible] for less.

Five ways to proceed

During the past year, I have been conducting an informal, unscientific survey among knowledgeable health services managers in a wide variety of health-related organizations around the country. Asked about the potential of the types of integration envisioned by the CCMC, almost all agree that with more coordinated and committed governance and community accountability and fewer regulatory obstacles, they would require much less money in the years ahead to serve their communities, patients, and enrolled populations effectively.

They feel that, theoretically, broad community benefit initiatives can be linked with narrower, more sharply focused entrepreneurial initiatives to provide much more with much less. They also believe that, theoretically, there are numerous opportunities for effective integration among the various "mindsets" or "subcultures" or "methodologies" (different individuals use different words for what has been poorly defined to date but is well understood nevertheless!) within the health field.

Most doubt that working together for a more effective community health system is feasible, even though they all agree that it would be far more professionally satisfying and much more fun than downsizing and competing for survival. A typical response: "You know, you are absolutely right, but it won't happen!"

Among those with whom I have spoken who visualize a more effective integrated system, there is a conviction that (1) extremely disciplined governance, and (2) management of tough, results-oriented business plans is the way to get started. In these discussions, most interest centered on five different initiatives, all of which have precedents in the history of healthcare as well as in my own personal experiences during the past half-century:

1. Consolidate duplicative, high-cost/low-use services into unified centers of excellence for the community and region, with higher quality at lower costs.

2. Use comprehensive, regional capitation to eliminate much of the unnecessary paperwork, financial transactions, and utilization controls now done by the separate elements of the health system. These elements, managed in synch, will provide the best services in a capitated community network committed to a common vision.

3. Consolidate and competitively contract for non-patient care support services—information systems, accounting, legal, purchasing, training, housekeeping. Such services currently absorb at least a third of health services expenditures. Even more savings would result from integrated competitive contracting for a wide variety of quality-controlled clinical services from investor-owned firms, as well as from community and professional organizations—without incurring antitrust penalties.

4. Downsize. At least 30 percent of the acute inpatient facilities maintained by the competitive system could be eliminated without creating any waiting list for beds in most communities. Even more expensive resources could be eliminated if managers focus increasingly on primary care that emphasizes prevention, self-help, and health promotion. More effectively integrated services for those requiring long-term care and rehabilitation in a variety of settings would also save money and achieve better results.

5. Integrate public health and community benefit programs. For the long run, the greatest potential for doing more with less is to be found in more effectively managed community benefit programs coordinated with expanded public health initiatives for healthier living conditions and greater community involvement. Even in the short run, significant savings are possible in carefully selected areas such as teenage pregnancy.

With integrated governance and management of community care networks, and avoidance of unnecessary regulatory obstacles, these five managerial initiatives could eventually bring health services costs in line with those of other developed nations. That would mean a reduction of as much as a third, as expenditures declined to absorb less than 10 percent of the gross domestic product, in contrast with the projected 16 percent or more. This would appear to be a feasible goal for the next seven to ten years, coinciding with and contributing to the goal of elimination of the federal deficit.

Movement toward a more integrated health services system will require a strong commitment by community leadership, including not only caregivers and those who govern and manage health services institutions, but also government, business, labor, and consumer groups. This in turn will depend upon three factors: (1) an understanding of the impending financial crunch and its potential impact on community health; (2) a vision of a reformed health system that will do more for less; and (3) a conviction that those responsible for the community's health services organizations know how to overcome legal, professional, and other human obstacles and take practical, incremental steps that will simultaneously bring some early initial results and strengthen the commitment to reform as expenditures decline. ●

Drawing on history to provide guidance for those who will be required to do a lot more with a lot less, future articles by Robert M. Sigmond will explore opportunities for integration among disciplines or methods of operation, among organizational entities and sectors, and between governance and management.

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