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## 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.

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### 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<sup>1</sup>. 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.

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### **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.

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### **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

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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.

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### 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

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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

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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.

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### 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,

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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.