1981 Ross Health Administration Forum

Community Forces as Regulators

Robert M. Sigmond

With the anticipated massive pullback in money and initiative by the federal government and possible reduction in money from corporate benefits managers, all the old regulators necessarily will be called on to do what they can to maintain some kind of predictability and order, as well as social value, in the health services field. In this situation, the oldest set of forces we know in this country—community forces—may take center stage with a whole new set of improvisations.

The pullback at the federal level already has started, and, as you might expect, it's having a serious impact on state and local governments, as well. In addition to cutbacks in Medicaid and Medicare and other specific health programs on October 1, 1981, the federal Community Health Services Administration (CHSA) will close up shop. According to a story in the *New York Times* on September 19, 1981, "Today the Community Health Services Administration operates on a budget of $542 billion with 1,050 employees, none of whom is being transferred to other government agencies. Administration officials estimate that the elimination of the agency will save about $40 million a year."

CHSA never operated on a budget of $542 billion. Its budget was $542 million, but that's the kind of error and confusion that characterize national views of community service. The real significance is not the saving of $40 million a year, but rather the closing down of one of the few reflections of interest in community forces at the federal level.

The massive pullback in money on the part of corporate health benefits managers is not supposed to start until new federal laws are passed regulating their activities to make them conform to antiregulation-procompetition theories. Meanwhile, fringe benefits payments always contract automatically during extended periods of high unemployment. When a person is unemployed long enough, all corporate fringe benefits are lost, and we appear to be in a fairly long period of high unemployment.

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Apparently, both government and corporate payments will be pulled back, in money if not in initiative. There also appear to be major new initiatives by business groups to regulate their own activities at the community level. Whether this turns out to be a community force as well as a business force is still open, depending on the role of the benefits managers as well as other parts of the corporation.

But if withdrawal of money from these sources is as massive as current national policy leaders anticipate, what will happen at the community level? Clearly, those institutions,

organizations, and individuals in the health field that have been motivated largely by economic goals can be expected to take strong defensive and offensive action to avoid adverse effects of reduced income flow. This will challenge the innovative capacities of institutions, organizations, and individuals who are motivated by concerns about their communities. And, in this interplay, the regulatory role will necessarily fall on the community's institutions, both those that follow the most self-serving strategies and those that are the subject of my talk, which are leaders in preserving and protecting community values.

The regulatory role will necessarily fall on the community's institutions.

Most people employed by hospitals and other community institutions know who the regulators are. They are the individuals who sign paychecks, who say "no" or "maybe next year" when we want to hear "yes" or "right away." For such employees, the managers of community institutions are the real regulators.

In a sense, they are right. Hospital executives and other community health agency executives are the regulators who must respond to government influence, business coalitions, economic forces, and consumer and professional demands and requirements. The burden falls on administrators to bring a sense of order and regularity to a complex scene dominated by high expectations and scarce resources.

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What forces become dominant during periods of cutbacks in health resources? We have had earlier periods of massive contraction of health services in our country. In each case, the burden was picked up by community forces with little outside help. As might be expected, the response was not optimum on the part of every organization and community, but the loss of life and well-being was less than might have been expected. I'm referring specifically to the severe cutback in health service resources during the Great Depression and World War II. In the first instance, the cause was a massive decline in the gross national product due to economic stagnation. In the second instance, the cause was quite different. Diversion of a large share of physicians, nurses, and other health service staffing, along with a healthy segment of the population, from the communities and a virtual cutoff of funds for capital investment in civilian health service sources resulted.

These were not easy times for community health service agencies, but most of them made it through. Innovation and new application of old ideas played a large part. The Great Depression saw the birth and early growth of Blue Cross and Blue Shield plans, as well as commercial insurance and other forms of prepayment. World War II saw the spontaneous application all over the country of an old idea—early ambulation—that virtually doubled hospital bed capacity without capital investment. Hospital emergency rooms and ambulatory care programs began to change their character,

and people in every community began to make more extensive use of self-care programs long before the professionals invented the concepts.

In both situations, capital investment ground to a halt, but the system didn't. Today is a good time for some enterprising students to study these two key periods. In adapting to the cutbacks, government did play a role, and some extremely imaginative economists probably will be able to identify some marketplace forces at work. But, in the final analysis, each community had to rely on its own resources and its own leadership, and the community forces were there and responded.

It's silly to expect community forces to work in the best interests of everyone and solve all the problems.

It's silly to romanticize about community forces, to expect community forces to work in the best interests of everyone and solve all the problems. But it's nonsense to assume that they don't make any difference simply because they are almost impossible to identify and quantify at the national level. They are important forces for good or ill and will not go away. Any formulation of the regulation of health services that does not take community forces into account is so incomplete as to be dangerous.

Let me be a bit more specific about my notion of community forces. Community forces are individuals, agencies, and organizations motivated by their concern for the well-being of the people in some geographic community in which they are located. They act at least in part for what they consider the best interest of that community, rather than broader or narrower interests. Few individuals or organizations are prepared to guide and regulate all of their activities exclusively on the basis of what's best for their community, but many find it difficult in regulating their own activities to disregard the community. The issue is not community interest versus self-interest. Rather, the issue is how to encourage a healthy balancing of community and other interests so that some degree of overlap and interdependence is incorporated into the decision-making processes.

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Generally, the smaller the community with which the company or organization is identified, the greater the threat to that community's stability, and the more likely that the individual or organization will identify community interest with more obvious self-interest. The plant manager in a one company-one hospital town will take an entirely different point of view toward his company's self-interest with respect to the town's hospital utilization than the company's national manager of fringe benefits costs or a plant manager in a multihospital-multicompany town. Companies have to consider that fact as they get involved in this subject.

In the single hospital-one company town, the plant manager is more likely to be interested in the hospital as a factor in recruiting and retaining a happy work force in the community than in simple fringe benefits costs. The physician on

the staff of a hospital with an explicit institutional commitment to a defined population in a specific community, which makes that commitment a major consideration in allocation of scarce resources, is likely to view the health service requirements of the people in that community much differently than a physician who does not depend on such an institution.

Community forces are pervasive and can be mobilized to exert strong regulatory power in specific situations when the conditions are right.

Community forces are pervasive and can be mobilized to exert strong regulatory power in specific situations when the conditions are right. The first condition for the mobilization of community forces is some recognition of a broad community interest by various elements within the community. Two other conditions already have been mentioned—size of the community, and the extent to which elements in the community are able to integrate self-interest with community interest.

Other conditions are important in determining the power of community forces in specific situations. Of these, the most important are the nature of the community leadership, the kind of formal or informal infrastructure developed over the years by that leadership, and the extent to which incentive systems can be structured to strengthen rather than to undermine community forces. And finally, the degree of tolerance of aberrant behavior in a community must be considered.

Consider each of these factors in relation to the subject of this forum—regulation of the health service system, particularly health care expenditures.

From a community point of view, cost containment is clearly a key element in any strategy to assure effective health services for the entire community in an environment of sharply shrinking resources. Health services as currently organized in most communities cost a lot of money. Health services will cost more money than likely will be available in the future. Therefore, those in the community who are interested in maintaining effective health services must direct their attention to containing costs, so that the available resources can continue to support some kind of a system of health protection that will be available when required in that community.

The know-how for communities to adapt to massive cutbacks in resources is available, just as it was during the Great Depression and World War II. It can be done without endangering the health of the people or the financial viability of essential services, so long as the focus is on the community. The real danger is that the key elements of the community may not consider the entire community as they respond to shrinking resources.

The health insurance plan whose only concern is the size of subscribers' premiums does more harm than good, no matter how attractive the benefits package and the price. The

hospital that focuses exclusively on services to patients who are able to pay may do more harm than good no matter how efficiently operated. The Fortune 500 corporation that acts only to hold down its fringe benefits costs without considering community impact may find itself caught by conflicting forces within the corporation and the communities where it is located. Separate but equal health services for the rich and the poor really cannot be supported in most communities—financially, morally, or managerially, the concept is unacceptable.

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Ideally, all who are involved should have broad concern for the community's total health resources as they deal with their own specific problems. Everyone won't do that, but many can be encouraged to try, and those who do try can become powerful community forces necessarily drawn into community action.

Almost all of the motivations and responses of community forces tend to be stronger in smaller communities—that is, recognition that certain services won't be available other than through community action, concern about one's neighbors, willingness to contribute more than one's fair share to the community, recognition of such unusual contributions, etc.

But effective regulation of health services in a period of scarce resources always has required the mobilization of community resources on a much broader basis than neighborhoods and similar settings. Except in unusual situations, however, community forces do not have major impact for the country if the community is very small. And they may not have a major impact on the community if the community has 250,000 or 500,000 people.

In the next few years, we will learn a great deal more about the subject of optimum size for community forces to work. The size of effective community units (neither too large nor too small) will be crucial in mobilizing these forces for regulating health services.

Integration of community interest and self-interest is necessary.

Integration of community interest and self-interest is necessary—community interest only achieves force when viewed in the framework of self-interest. Amazing results are achieved when a wide range of community elements begin to make decisions based on what often is called enlightened self-interest, and when some critical mass of common forces unites and identifies some element of community interest.

Community force is not achieved by pitting those who put community ahead of self against those who put self ahead of community. Such a confrontation is bound to be self-defeating. Every element of community will approach the question of community interest from its own self-interest. One can hope to broaden the perspective, but community interest not identified with self-interest loses its force; it really

has no force. Successful motivation of community forces always has involved identification of community interest with a variety of self-interests.

Community leadership and infrastructure are inseparable elements in mobilizing community interest to become community forces to be reckoned with. Leadership is inextricably linked with followership. Community leaders are those from special interest groups who are able to identify, articulate, and act on their own group's unique, enlightened self-interest without losing their basic identification with that group's particular interest. This type of leadership has existed in communities such as Rochester, Pittsburgh, and to some extent, Detroit, for years. It appears to be emerging in such other cities as Akron, Toledo, Atlanta, and Minneapolis.

It may not be just an accident of history that this past month the American Hospital Association's (AHA's) House of Delegates adopted a new statement on hospital leadership that has been hammered out over the past 2 years guided by Gail Warden and Irv Wilmot. The AHA's leadership statement sets forth the obligation of hospital trustees, medical staff, and executive management to have as their primary mission the improvement of the health and well-being of the people in their communities.

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If only one hospital in every community attempted to carry out this kind of leadership, now incorporated as fundamental AHA policy, the whole issue of regulation of health services would have to be reformulated. This policy statement really views the hospital not just as a provider agency, but as an agency that reflects the interests and concerns of providers and consumers, and sets a whole new standard for hospital leadership.

Whether or not this statement will begin to have the kind of force that will regulate hospital behavior in various communities is still to be seen.

Leadership is not enough as, incidentally, the AHA statement makes clear. Some kind of infrastructure is required through which those who are committed to community forces, those who are community forces, can get together, to share experiences and insights, strategies and work plans. In this respect, formal structure and representation are not as important as commitment and a spirit of cooperation. Community forces can begin to achieve unbelievable power when those who can make a difference get together in settings of mutual trust and shared confidence.

Hospital consortia and business coalitions that are at opposite ends of the pole now may be a necessary transitional step from the adversarial atmosphere of the Health Systems Agency (HSA) era to the new community health coalitions beginning to take shape. If hospital consortia and business coalitions recognize the necessity to address community

problems, they almost inevitably will come together as a powerful community force.

Mobilization of community forces will require reconceptualization and restructuring of incentive systems in the health services field.

Mobilization of community forces will require reconceptualization and restructuring of incentive systems in the health services field. We've heard a little about that. The complex set of interdependencies in the health field provides a rich atmosphere of give and take that is the framework for a wide variety of positive and negative incentives—some hard financial incentives and some softer, but just as real. Community commitments and obligations can be built into all contractual commitments and transactions, no matter what they are.

Medical staff appointments, licenses, accreditation, third-party contracts, capital investment, philanthropy, tax exemptions, patient-physician relationships—all can be transformed into powerful community forces by dealing with them in terms of incentives. This is an extremely fertile field, which some Blue Cross plans and some self-insurers have begun to cultivate. There is much opportunity here for turning community aspirations into community forces by enriching the conditions for give and take.

For example: The hospital makes it a condition of a hospital staff appointment that a physician can't turn down Medicaid patients or those who have lost Medicaid benefits in federal cutbacks. That will have a profound incentive effect. In mobilizing community forces, acceptance of aberrant behavior is terribly important and not understood. Acceptance and protection of aberrant behavior symbolized by the village idiot, the town drunk, the Greenwich Village eccentric, the millionaire, the miser, the philanthropist, or the so-called community hospital that won't go along is the true distinguishing characteristic of the American community.

Community forces usually protect aberrant behavior even as they identify it as such. Tolerance of nonconformists, tolerance of antisocial behavior is an essential part of the process of endorsing, embracing, and rewarding ever-higher standards of community service. Community forces seldom trade on negative incentives. The objective is not to punish self-serving elements or aberrant elements in the community. If punishment is required, there's always the government with its police powers. The major weakness of the HSA as contrasted with earlier forms of community-focused health planning agencies was the emphasis on stifling aberrant behavior and prescribing acceptable behavior in deadening detail. Community planning agencies of the future ideally will avoid this mistake, which can only create a barren environment for mobilization of community forces. The emphasis should be on the greater rewards of community service as contrasted with the lesser rewards of self-service.

A great deal more could be said about community forces and how they can be mobilized to regulate the flow of money, resources, and energy in the health field to achieve better results. Ideally, there would be time for detailed research to determine how best to mobilize community resources in relation to the factors mentioned and how to avoid the many pitfalls and frustrations of the past. The best we can do is to try to refine the kinds of impressions and hints that are set forth in this paper.

What is called for is a variety of demonstrations in various communities throughout the land.

What is called for now is a variety of demonstrations in various communities throughout the land. Some philanthropic foundations appear to be ready to support such demonstrations, and many communities appear to be ready to apply the lessons learned from the various abortive community-focused efforts of the 1950s, the 1960s, and the 1970s to the complex environment of the 1980s. For effective regulation of health services, no other alternative may be available today.

Panel Discussant

Roderic M. Bell

I would like to comment on Mr Sigmond's remarks about the community's influences as a regulator, as a stimulator, and as a force in hospital and health activities. I am in Texas, where the local communities tend to generate things they need in terms of health. They are generous about putting up money for health systems.

Texans tend to resist regulatory process in any form if it comes from outside the bounds of their own city or county. That's been a tough problem in the last several years, but our people have responded to it. Not only health care but also other social services and the arts have been well served by local community forces, and this has brought a balance between health and the arts and the more gracious things of life. We've been fortunate, as a relatively new, pioneering area, in having a sense of "can do" and "will do," and we will take care of the things that we need for our local environment and life-styles. Health services, particularly, have benefited from this type of attitude and environment.

The pendulum is starting to swing back politically. More local control will return, and local control implies local initiative.

I hope there will be more of these attitudes across the country. I suspect we're starting to see the pendulum swing back politically. More local control will return, and local control implies local initiative as well. It doesn't mean the negative part, it means stimulation of the positive part. The things our communities need will be initiated and generated within the local framework. This story will illustrate my sense of community participation and policy direction.

In the mid-1950s, a powerful banker in Dallas named Fred Florence, chairman of the board, chief executive officer of Republic Bank, was associated with a local Catholic hospi-

tal. Fred called half a dozen people together and asked, "What's the hospital situation?" One of the sisters replied that Dallas was on the verge of a major population explosion and that the hospitals were, by and large, getting behind the nation. Mr Florence accepted this and said, "We can't do it all at one time."

The situation in Dallas goes back to money, which is one theme of this conference—some say lack of, some say too much. Dallas has a controlled system of fund-raising. You don't go out and raise money without the blessing of the Citizens' Council—50 top executives in banking, insurance, etc who control the system and schedule the fund-raising activities. You ask permission and you get a good spot—1, 2, or 3 years down the road.

In Dallas, if you don't have the seal of aproval from the Citizen's Council to raise funds, you haven't got a chance.

The capacity for gift funds of the city has been about $60 or $80 million. When the city gets close to that, the Council starts putting things off. The citizens tend to support this. In short, if you don't have the seal of approval from the Citizens' Council to raise funds, you haven't got a chance. You don't get money from foundations, banks, insurance companies, or anybody else. With the seal of approval, the banks will pick up 5% of your campaign, the utility companies about 4%, the rest of business 4%, and one or two foundations another 2% to 4%. You go in with 15% or 20% toward your objective.

The key to all this is that in 1956, the Citizens' Council said, "You hospitals get together and decide whose need is the greatest. We will set up dates for you in alternate years, with the hospital that has the greatest need coming first." Mr Florence has been dead for 15 years, but this pattern still exists. The community has accepted this as an ongoing responsibility, and it's been a major contribution to health care in Dallas. This is what I mean by community activity and community regulation.

Last week, the mayor convinced a local company to give a $3 million piece of land in the heart of downtown for the fine arts center as a tax deduction. We're going to have another major center in the heart of the city as a result of broad community action. The $3 million gift that this company gave is being matched by $22 million, half in tax funds and half in gift funds that already have been committed.

Through community activity and involvement, we tend to regulate ourselves positively rather than negatively.

This story about Dallas can be applied other than to health care, and it represents an attitude about results, an achievement of things that are good for a particular community. Houston does equally well. Some other cities in Texas are not this good, but they are stronger than those in many other states. This is the positive part of the answer. Through this process, we tend to regulate ourselves in a positive rather than a negative fashion. The results have been gratifying, and they will continue to be so for many years, because new people become caught up in these attitudes, and leader-

ship follows this same pattern because it's been good for them. This is how we approach the business of community controls in meeting our individual citizens' needs.

Panel Discussant

Thomas G. Parris, Jr

As a member of that high-risk occupational group that must maintain the degree of predictability Mr Sigmond refers to, I'd like to share with you four concerns of the front-line manager, whether a hospital administrator or a community agency leader. The four areas are 1) the integration of community interest and self-interest; 2) the rate of change, or the expectation of the rate of change by all those constituencies that we discussed; 3) the involvement of physicians in this whole process of change; and 4) the adequacy of management information.

Dr Somers discussed a taxonomy of constituencies within which the management process occurs. We must deal with various kinds of consumer groups to make change, and the dynamics of that vary from moment to moment, period to period. Our circumstances now are different from those of the recent past. It's wrong to assume that front-line managers are fully aware of the diversity of consumer groups, and that they all understand the extent to which one group may be biased. If I, as a manager, am going to deal effectively with one of those groups and if there is to be any positive change, I have to put the group's strategy into a broader societal or community context. One of the most important regulator groups that was omitted from Dr Somers' list is physicians and other health professionals. Physicians and other health professionals consume the greatest majority of health care resources. That's what we're really talking about, not just the new mother who wants family-centered maternity care. Most of the front-line managers don't appreciate how much bias or ignorance or lack of awareness is shown by that health professional. A physician may say, "I'm concerned about the quality of life. I want these resources, and that's it. I don't want to hear anything about those external world forces or anything else." The reality for some poorly managed or structured institution is that you deliver or else.

One of the most important regulator groups is physicians and other health professionals.

These four things, then, are highly interactive: the involvement of physicians, management information, the rate of change, and the integration of community interest and self-interest. If the physician had a different awareness about the totality, he or she might act differently and place different demands on the system for change. This is true of any special interest group; it most likely will have a highly focused and extreme bias about what it wants from the system.

We have to begin to integrate those concerns, needs, and objectives and arrive at a consensus. Therefore, we have to

make a greater effort to educate all those constituencies about the totality, ie, to work within the system and that broader, interactive context.

Similarly, we may characterize the participants' expectation of the rate of change. Unless we get down to a practical level and force the addressing of these impediments, we'll be back here next year and the year after, etc. We'll never begin to make positive change. As I indicated, most special interest groups approach us in a different way. They have certain objectives, and they make no bones about it. If it's the third-party payers, they're looking at the bottom line. They say, "We want to negotiate line by line." My colleagues don't want to negotiate line by line because they may be very vulnerable. How can I get into things like incentives, positive ones? Or, how can I defend keeping certain dollars in my base unless I can begin to dissect the cost components? Obviously, if I am underfinanced, I would prefer dealing at the specific rather than gross level to force a greater accountability on payers for cost containment decisions.

Third parties may say, "We have only this much money to support your overall programs. Therefore, you will have to reallocate resources and modify your operating budget within this next operating period." This may not be realistic. It could take you years to change operating patterns, and it may take you even more years to recoup from a bad short-term decision that will have long-term, serious consequences.

I am a strong advocate of greater, more informed participation by physicians in the management and governance process.

I am a strong advocate of greater, more informed participation by physicians in the management and governance process, and that does not necessarily mean sitting on a board of trustees. The participation is not happening because of resistance from my colleagues and resistance from physicians, perhaps a majority of them. It's lack of attitudinal as well as educational preparation at all levels.

I suggest, however, that physicians will stand naked in terms of scientific, technological capabilities unless they learn and are prepared to work within a system that deals with the rest of that system—all those other dimensions we have talked about these last couple of days. Otherwise, they will never be able to translate those capabilities into improved health care delivery, individually or collectively. All these other forces out there, despite what you have heard from our previous speakers about business coalitions, etc, want to know what kind of outcome they will get for their investment.

I urge that we attempt to restructure our medical education programs at all levels—undergraduate, graduate, and continuing medical education.

I urge that we at least attempt to restructure our medical education programs at all levels—undergraduate, graduate, and continuing medical education. I don't mean just a couple hours per year, but some continuing, intensive exposure for both new and practicing physicians to the realities, and some guidelines for working within the system.

Such guidelines should not cover how to run an office practice alone, but rather how to work within a hospital and

how to work within the broader community of institutions that Bob Sigmond refers to. An attitudinal change is needed, and that's the purpose of the American Hospital Association's (AHA's) leadership documents, that is, interdependent relationship roles rather than the standard independent approach.

The recent American Medical Association House of Delegates meeting bore out my concerns with all their resolutions about "Let us get a crack at the trustees first and leave the administrators out. We want to give them the doctor's perspective." I say to them, the practicing administrator is your best advocate if you're a physician, not your adversary. The administrator knows how to deal with and manipulate the system, ie, how to take scarce resources and turn them into an environment for practicing better medicine.

We have discussed another major concern, the inadequate management information systems. I don't know how you determine cost benefit. Neither do I know how to define productivity, standards of care, or quality. I'm embarrassed to admit that to my other friends in industry. They tell me that the automotive industry and others are not as sophisticated as they think they are, but from what I've seen they appear to be more sophisticated. Unfortunately, we as providers are at a great risk of being clobbered by gross indices. Frequently, we hear that "costs have gone up by X percent," or "your cost per day is X." You have to look at what the parts of those costs are before you can make intelligent decisions about reallocation of resources or intelligent planning decisions. I hope we'll have people in positions who are prepared to understand what planning is, and who'll be committed to showing differential cost benefit as a basis for making decisions. How do you have a price-sensitive market? How do you construct price when you don't know what the cost components are? I don't know how, and that's why I suggest that this is a major area where we need help.

Focus Group Report On Duane Heintz's/Robert Sigmond's Presentations

Some participants felt that business coalitions might be characterized as buyers who were interested in a defensive ploy in a period of constrained resources. One rather large motivation among this group is a disinclination to pick up the slack that's been created by the federal withdrawal. What is the motivation of the participants in these business coalitions? Is it merely cost, or are quality and access considerations also important? Are the business coalitions simply out to cap expenses as the feds would like to do and as other groups have proposed in various places? Even though that

may be their objective, unlike the government, at least coalitions offer a willingness to work with the provider community and not to simply impose these things unilaterally without discussion.

Some people perceived business coalitions as a real threat to the delivery system; once utilization is cut, prices are next. Another feeling was that coalitions are totally uninformed. This is frightening to health administrators, because as government pulls back and retrenches, cuts on reimbursement, and tries to extract itself, business will increasingly become a dominant force. Insurance also will become much more activated, driven largely by the business corporations around the business premium dollar. The groups agreed that there may be a significant risk in benefits managers' acquiring too much influence and power. Troubles could result as their influence grows.

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There was also a concern that within the business community may be an inherent conflict of interest. The chief executive officer (CEO) often has a role as a trustee in a community institution service. Yet, within the CEO's business organization, the benefits manager's objective is likely to be to minimize the expenditure of the firm. The CEO somehow must balance this self-interest of the corporation with the community interest represented by his trusteeship.

Another problem is that if business coalitions are self-contained without much input from health care leadership, they may simply reinvent many of the processes that health providers already have developed. A lot of the early work on business coalitions is focusing on building data bases. One danger is that in the early stages everyone wants the best data available and to build the best data system. Business coalition progress could be slowed by the fact that you never have all the data that you need. If the business coalitions spend a lot of their time over the next year or so trying to get all the data, ultimately they may be lost. That's why the groups felt community linkages should be fostered early, focusing on a few manageable tasks and moving to those quickly. In this sense, the focus groups could see some positive, productive results coming out of these efforts.

By the nature of the coalition-provider relationship, when the two get together, the dialogue and effectiveness seem to be diminished. We're probably in a long process of change where each group will need to meet separately at first, getting input from one another, before the confrontation and the joint effort come to pass. Cost and quality must be kept in balance, and business coalitions must know this if they are to be successful.

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The solutions designed may well exclude the poor and the near poor, creating a two-tier system of health care. Reimbursement considerations limit the ability of the teaching hospital to prevent the two-tier system from developing. If

the medically indigent are diverted into community support institutions, county hospitals, and city hospitals, the quality of service necessarily has to deteriorate because of a lack of resources at such institutions. It was suggested that these types of institutions ought not to exist and that patients now supported by the community for their health care preferably would be sent to private organizations.

It was pointed out that court decisions have made it mandatory that local governments be responsible for people in this category, but such laws would not prevent them from being sent to private organizations. The focus groups were emphatic that, unlike where a hospital simply agrees to provide all the services needed for medically indigent patients, this program would be an explicitly negotiated agreement for X number of services at a level of quality for a set group of people. The agreement would not be open-ended, with the administrator of the institution stuck with trying to figure out who doesn't get what available services. Perhaps business coalitions can help support a new type of health care structure that better serves the community.

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The focus groups noted that individual corporations like the Deere Company, for example, are having some success. However, most business coalitions are not as far along. Most are still talking, trying to figure out what they can do. When the business coalitions and community forces as reflected by health care leadership are considered, a need emerges to mesh these forces. People are concerned that the emergence of business coalitions reflects segmentation within the industry. Coalitions are corporate in their identity, and they do not involve the medical leadership. Resolving the cost issues that are bringing the business coalitions together is crucial. To that end, the corporate leaders, the architects or stimulators of the business coalitions, must be brought together with the health care leadership to make the business coalition part of a broader community orientation toward health.

This bringing together of business and trustees, labor and physicians, and other community forces at the highest corporate level ultimately will benefit the patient. Such a broad community group can respond in terms of access to care and quality, other forces that are just as important as cost.

Ultimately, by bringing these forces together—those who have been involved in the delivery system with those who are worried about paying—we have the opportunity to mutually solve our problems.

More information-sharing is needed across these lines. The health care leadership needs to know much more about the concerns of the business community and vice versa. At some point, the issues could come to a community forum from which the ultimate issue can be addressed—how to best serve the patient.

By bringing the business and health care leaderships together, some positive, built-in relationships can occur. As noted earlier, business leadership is an important ingredient of health care trusteeship. This natural linkage can be productive to both sides. The focus groups felt strongly that broader community leadership in the health care industry wants to assist coalitions as they get going, focusing on very positive objectives.

Providers — hospitals — are notorious for lack of knowledge about their own benefits plans.

One admonition that came from the focus group discussion is that providers—hospitals—are notorious for lack of knowledge about their own benefits plans. Hospital directors might take a look at the dollars spent and the kinds of programs that the hospital is conducting for its own people.

The view was expressed that a hospital is not a social agency. It may be an agent, but not an agency. In some communities, the health care industry is the single largest employer. Even within the health framework, then, self-interests must be considered and how they are tied up with community interests. Self-interest is not easily diverted into the community in this country, and short-term self-interest is really competitive.

After discussing the nature of community leaders and the nature of the organizations that emerge within a community in terms of creating leadership, the focus groups concluded that all communities do have some leadership structure. Even in cities like New York, significant groups have emerged as community leaders. Of course, community forces differ as environment or geography differs.

The physician is a significant force in molding the future of health services. Running a medical care system without doctors is difficult, and they must have a role in the system. In terms of community trends, the groups noted a significant increase in group practice throughout the country, reflecting an increasing dependency on medical teams. There were some thoughts expressed that physicians of the new generation seem to have some epidemiological approaches to the practice of their profession. Some felt that when the physician encounters the greenback, these trends sometimes are diverted slightly, and that the new generation of doctors seems to be different in terms of their interests in primary care, prevention, and matters beyond acute care.

There are highs and lows in community interest, and now probably is one of the low spots.

The focus groups discussed the analogy between the current situation and the eras of World War II and the Depression. They agreed that community interest and the coalescing of interest groups is like a roller coaster. There are highs and lows in community interest, and now probably is one of the low spots. In years to come, new types of coalitions will emerge. Unlike some past coalitions, providers should be active participants in them, and consumer representation should not be required for every miniscule subgroup. Situations where one must search desperately to find the per-

son that can qualify to become a member of this group should be avoided. Broad representation is desirable, but within some obvious limits. One final and important message from Bob Sigmond is that there now is great opportunity for the health leader. He or she should seize this chance to become the catalyst, the initiator, who will lead the formation of these community coalitions.