

Re-Examining the Role of  
the Community Hospital  
in a Competitive Environment

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*The 1985*

*Michael M. Davis Lecture*

CENTER FOR HEALTH  
ADMINISTRATION STUDIES  
GRADUATE SCHOOL OF BUSINESS  
DIVISION OF BIOLOGICAL SCIENCES  
UNIVERSITY OF CHICAGO

## THE SPEAKER

Mr. Sigmond is a statesman of the health care field closely identified with the evolution of planning and reimbursement incentives. He has made Pennsylvania his home and served there in numerous capacities, including executive director of the Hospital Planning Association of Allegheny County in Pittsburgh, executive vice-president of Albert Einstein Medical Center in Philadelphia, faculty member in health administration at Temple University and at the University of Pittsburgh, and member of the national advisory committee to the Leonard Davis Institute in Health Economics at the Wharton School. He has served in editorial capacities with many journals including the *American Journal of Public Health*, *Health and Society*, *Health Services Research and Medical Care*. Mr. Sigmond has held key positions with the American Hospital Association, Blue Cross Association and The Hospital Research and Educational Trust. His extensive contributions have been recognized by award of the Dean Conley prize for best article by the ACHA (1969) and the Corning Award (1981) by the Society for Hospital Planning. Mr. Sigmond is a graduate of the Pennsylvania State University.

## THE OCCASION

Mr. Sigmond delivered this lecture at The Ambassador West, Chicago on May 10, 1985.

## I. INTRODUCTION

When the federal government first became involved in national health policy just after World War II, the community hospital was viewed as the key to the development of comprehensive, personal health service systems. Until the late 1960's, community hospitals appeared to be meeting this challenge, as they provided the organizational framework for an astounding expansion of geographically accessible technology, new medical specialities, and new service programs, all under professional and community control, guided by voluntary accreditation standards and government regulation. Every state had an official hospital plan which provided for local community hospitals to be readily accessible to everyone. These local hospitals were to attract and backup community medical practitioners, and in turn were to be backed up by more technologically intensive district and base hospitals, which also served their immediate communities. Through the planned hospital network, comprehensive health services were to be available to everyone in need.

About 20 years ago, evidence began to accumulate that health care costs were getting out of control. The hospitals were identified as a major part of the problem. They were soon seen as hungry giants, capable of absorbing unlimited funds, dominated by medical specialists and obsessed with keeping their acute inpatient beds occupied, rather than with the mission of keeping people healthy and improving the community's health status. The notion of the community hospital as the focus for ever more cost-effective, accessible, high quality, comprehensive, humane health service systems gradually lost its credibility.

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Substantial changes have been incorporated in this version of the lecture from the presentation at the University of Chicago Symposium last year. These changes reflect valuable suggestions from Dan Barker, Howard Berman, Emily Freidman, Eli Ginzberg, Tom Kinser, Tony Kovener, Wayne Lerner, Beaufort Longest, Rich Maturi, Alexander McMahon, Walter Mc Nerney, C. Rufus Rorem, Steven Sieverts, I. Oscar Weissman, M.D., Marc Voyvodich, and my dedicated graduate assistant at Temple University, Ms. Elaine Ritter. Needless to say, I assume full responsibility for the inadequacies of the revised version.

Currently, health policy experts advocate commercial competition among individual hospitals for a larger share of a shrinking acute in-patient market. This competition is expected to force downsizing and hospital closures as more and more health services move away from the community hospital.

The thesis of this lecture is that the time has come to re-examine the notion of the community hospital and the role that it can play in the nation's personal health services. I suggest that this institution continues to have great potential for spearheading reform to achieve more cost effective, comprehensive, accessible personal health services. To overcome hospital resistance to assuming leadership, strong incentives will be required, with preferential treatment of those hospitals which meet new standards of community hospital performance. The results could be dramatic even if only ten percent of community hospitals shifted their major resource allocation from acute in-patient care to a wider spectrum of community health services, with major emphasis on ambulatory and home care. This approach has the potential to reduce the level of health expenditures, while increasing the quality, accessibility, and effectiveness of care, and without excessive disruption to community life. For many communities, this may be the most feasible approach to improving health services results, as available funds become more constricted.

Today, the community hospital — defined as one which is concerned about the health of the people in its community — appears to be an endangered species, as more and more institutions place commercial objectives ahead of specific community service goals. This development is tragic, because rejuvenated community hospitals could contribute so much to solving the country's problems in personal health service. Furthermore, the transformation of community hospitals into entrepreneurial purveyors of in-patient services threatens to create major gaps in community health service systems.

The current national emphasis on market-oriented alternative delivery systems, in contrast with the more comprehensive approach of the health system agencies, encourages sub-system development at the expense of essential system-wide elements. At risk are all those elements of the community's health system that are not clearly market-related — service to the disadvantaged,

high cost/low use services, and long range capital investment in future innovation and quality. Many hospitals continue to maintain basic community commitments to these essential elements of the comprehensive health service system, but the competitive pressures threaten to undermine these commitments.

Hospitals currently are under great stress. Many are in danger of losing their way in their efforts to meet traditional accreditation standards, to respond to community needs, and to survive in a highly competitive marketplace. Nevertheless, the past history of responsiveness of hospitals to community and professional imperatives, often with a significant time lag, indicates that we are not yet past the point of no return. With appropriate incentives, many community hospitals can adapt to a changing environment, and provide leadership in making the full range of personal health services available on a cost-effective basis.

The remainder of this lecture will (a) outline some of the unique, traditional characteristics of a community hospital that are endangered and that appear to offer potential social value in the period ahead; (b) suggest some incentives that could encourage hospitals to attempt to achieve this potential; and (c) outline some new standards that can be used to identify those community hospitals that deserve preferential treatment in new incentive systems.

## **II. UNIQUE CHARACTERISTICS OF THE COMMUNITY HOSPITAL: PAST HISTORY AND FUTURE POTENTIAL**

Community hospitals have exhibited six characteristics in the past that in combination represent a potential for reducing the cost and increasing the effectiveness of personal health services — if adapted to today's competitive economic environment. In some hospitals today, particularly religious institutions, most of these characteristics are quite evident, infusing every aspect of the hospital's programs. In others, they are almost totally forgotten. Most community hospitals reflect at least some of these unique characteristics, and a potential for much fuller development.

### *A. Responsiveness to Community Requirements.*

The typical community hospital has always been governed by individuals who are supposed to serve as trustees for the community, as required by the hospital's Articles of Incorporation. Legally and morally, the trustees are accountable to the community to assure that the hospital operates in the community interest and responds to community health service requirements.

Unfortunately, current hospital standards do not clearly focus the institution's responsibilities in terms of the current issues facing the health system in every community: cost-effectiveness, accessibility, redundancy, and humane quality standards. Current standards focus primarily on safety, fiscal responsibility, and classical clinical processes underlying quality of care, reflecting the key public issues of a half century ago. By and large, community hospitals have responded to these traditional standards in a most responsible way. There is every reason to believe that many, if not most, would respond as responsibly to new, higher standards related more specifically to current community-wide issues. Historically, almost all community hospitals have always placed accreditation requirements ahead of commercial requirements. Almost all hospital trustees want to do the right thing, and have generally reflected the broad community interest, when those issues are clearly drawn in relation to their institutional responsibilities.

A listing of non-commercial services currently provided by community hospitals illustrates community hospital commitment, even without any specific accreditation standard. These include high cost/low use services that cannot possibly break even financially, such as pediatrics and trauma services, as well as services for which there is virtually no market at all, such as social service.

Because a significant proportion of hospital trustees are associated with business corporations, unions and other groups with a direct interest in current issues of community-wide cost effectiveness, hospital governing bodies are likely to respond to explicit standards of behavior related to these issues.

### *B. Acceptable Organizational Framework for Stronger Medical Discipline and Quality Control*

From the end of World War I until the past decade, the community hospital's medical staff was recognized as the major organizational mechanism for medical discipline in this country. Accepted by the medical profession, reflecting a unique balancing of physician self-governance and community control, the hospital medical staff organization exerts a continuing day-to-day influence on physicians and on medical practice standards. Every good community hospital limits the admitting privileges of all members of the medical staff, recognizing that no licensed physician can be proficient in all aspects of medicine. All good community hospitals in this country require physicians to maintain medical records of a quality unheard of anywhere else in the world. Furthermore, all good community hospitals require the medical staff to provide quality medical care for all of the hospital's patients, especially the patients who do not have the ability to pay for the care. With expanded community hospital outreach programs and medical staff involvement in new programs of managed care, the community hospital medical staff's potential to serve as a self-disciplined "group practice a la carte" can become a major factor in quality control and cost-effectiveness in the community. But hospital medical staffs will require new standards of quality control.

Today, a hospital's medical staff efforts to control utilization and quality are increasingly characterized as equivalent to "the fox guarding the chicken coop". This view demonstrates how far short community hospitals have fallen from fulfilling their potential as the community framework for medical discipline. Adherence to higher standards should correct this situation rather quickly, while greatly reducing the costs of the fast growing external medical review and managed care industries. These external activities could be greatly streamlined and function more efficiently if coordinated with more effective medical staff organization in community hospitals.

### C. *Commitment to Low Costs*

Throughout their history, prior to the enactment of Medicare, community hospital trustees were dedicated to holding costs down, primarily a reflection of the philanthropic effort required when costs exceeded available income. Even at this time, the costs of operating non-profit hospitals are at least as low as the costs in comparable investor-owned hospitals, including those which place stockholder interests ahead of community interests.

Currently, hospitals have no cost containment standards, as have been developed for Blue Cross and Blue Shield Plans. Explicit standards for community hospitals in managing and containing costs could easily be developed, based on current state of the art. There is every reason to believe that most hospital trustees would welcome such standards.

### D. *Commitment to Cooperation and Sharing*

Community hospitals have always shared their most important resource: their medical staff members. These physicians not only represent a key linkage between the institution and the people served, but also the key linkage with other hospitals and health service organizations. Although these linkages have usually been extremely informal and unstructured, they do provide the basis for community hospitals to plan in terms of comprehensive care for their patients without duplicating services offered elsewhere.

The impact of this informal regionalization of services on costs and quality has been significant. Aside from extended care facilities, however, explicit standards on affiliations do not exist. More explicit standards with respect to affiliations could greatly improve community health services — in terms of both costs and effectiveness. This would be particularly true if hospitals meeting appropriate community service standards were explicitly exempted from anti-trust restrictions that encourage counterproductive competition and arms-length relationships rather than cooperation.

### E. *Commitment to Cost Shifting*

Community hospitals have always demonstrated a capacity for shifting costs from the sick to the well, and

from those without money to pay for service to those with greater resources. This capacity has been reflected in various approaches to philanthropy as well as in social insurance mechanisms, such as Blue Cross, special contracts for the unemployed, and in pricing policies.

This capacity for community financing is rapidly eroding, in the absence of objective standards to assure the community served and major purchasers that these practices reflect inadequate government programs and community necessity, rather than unfair discrimination and exploitation.

### F. *Commitment to Service to the Disadvantaged*

Community hospitals started in the United States in the 18th and 19th centuries with a primary commitment to service to disadvantaged populations. With the expansion of services to patients who could afford private physicians, most community hospitals continued to maintain *preferential* treatment (not more *luxurious* treatment) for the disadvantaged, including the services of the institution's physicians for ambulatory care as well as in-patient care, with no fees to those who could not afford to pay.

This commitment is particularly important in view of the inadequacy of government programs for the disadvantaged, and the fact that most families with serious illness are likely to find themselves in the medically indigent category at some time.

Without strong incentives and clear objective standards for distinguishing the deadbeats from the deserving, the commitment of community hospitals to the disadvantaged is jeopardized in a competitive environment.

In summary, community hospitals in the United States until recently have had an unusual track record of responsiveness to community forces (economic, social, health) reflecting both flexibility and stability. In the absence of new incentives and standards, the current pressures to transform these community institutions into commercial ventures are likely to be overwhelming. The time has come to consider new incentives and standards.

### III. HOSPITAL INCENTIVES FOR COMMUNITY SERVICE

A wide variety of incentives are available that might encourage hospitals to meet higher standards of community service and thereby play a constructive role in the health services system reform. Some involve government, such as special tax treatment and eligibility for special funding programs; others involve philanthropy, and still others involve the professions, the marketplace, and financing agencies.

#### A. Tax Exemption

Exemption for hospitals under the federal income tax laws can be justified only on the basis of specific community benefit. A hospital that operates primarily as a commercial enterprise — whether a for-profit or a not-for-profit corporation — is not legally entitled to tax exemption. During the period immediately ahead, in the absence of objective criteria of community benefit, federal income tax exemption will probably be lost to hospitals. Many Washington officials believe that few hospitals have sufficient commitment to activities which benefit the community to warrant special tax treatment. Why not develop tough standards for hospitals that want to qualify?

The threat of losing federal income tax exemption, especially if combined with state and local tax exemption, can become a powerful incentive for some hospitals to meet high standards of community service. Others may wish to pursue a simpler commercial marketplace approach. Appropriate linkage of objective standards of community benefit to tax exemption is probably the single strongest incentive available to reward community hospitals (and vice versa).

#### B. Tax-Exempt Bonds

The same rationale holds true for tax-exempt bonds, which should be available only to hospitals meeting explicit community service standards, both with respect to capital investment and service. Currently, community service return on investment carries little weight in tax-exempt bond ratings, relative to financial return.

#### C. Tax-Exempt Philanthropy

Similarly, gifts to hospitals should only be exempt to the donor if the hospital meets explicit “community benefit” standards. Many hospitals with 501-C-3 ratings could not pass such a test.

#### D. Anti-trust Exemption

An equally important incentive available for use by government involves the application of the anti-trust laws. Current anti-trust provisions could be amended to apply in the hospital field only to those hospitals primarily engaged in commerce. Community hospitals should be exempt, based on a precise definition of the term “community hospital”.

These four incentives represent a powerful package available to government, all of which require the development of credible, objective standards to distinguish community hospitals from commercial hospitals. The government could not be expected to develop these standards without major input from the voluntary sector and the professions.

#### E. Eligibility for Grants

To the greatest degree possible, those financial requirements of community hospitals uniquely tied to their community service commitments should be financed by grants, and excluded from the prices charged for services. Such grants could be made by corporate foundations, other philanthropic foundations, individuals, government agencies, and financing agencies, such as Blue Cross and Blue Shield, HMOs and PPOs. The federal government essentially took this approach with the Hill-Burton hospital construction program, as did most corporations in funding new hospital buildings and equipment in the pre-Medicare period. Such arrangements can support lower prices for service and greater discipline in capital investment. Such grants could apply not only to capital investment (which should be viewed both as a community and as an institutional investment), but also to funding of innovative projects, educational programs, special programs for the underprivileged, non-marketplace services such as social service, and high cost/low cost use services such as burn units. Such grants might cover as

much as 20 percent of community hospital budgets, with resulting potential for reduced hospital contract prices.

#### *F. Preferential Benefits for Services*

Using selective grant programs as outlined above, preferred provider organizations can offer preferred benefits to their subscribers who use community hospitals that are eligible for grant awards and agree to reduced contract prices. This could represent another powerful incentive for hospitals to adopt higher standards applicable to community hospitals, but not to commercial hospitals.

#### *G. Eligibility for Participation in Medical Educational Programs*

An important incentive for many hospitals is the privilege of participating in the advance education of physicians, nurses and other professionals. Many hospitals carry out a wide series of complex and costly activities to avoid losing a residency training program. Educational accrediting groups could significantly impact members of the Council of Teaching Hospitals if training programs were limited to hospitals which meet explicit standards of community service as well as educational standards. Most of the nation's outstanding hospitals are in this group.

Some teaching hospitals view community hospitals as those with no commitment to educational programs. From my point of view, all teaching hospitals should be committed to community service. A teaching hospital that is not also a community hospital probably has an inherently flawed teaching program, particularly with respect to the perspective it provides to future leaders in the medical specialties.

#### *H. Eligibility for Special Accreditation Recognition*

Finally, special public recognition could be provided to those hospitals which conform most closely to high standards of performance in community service. Past experience indicates that there would be spirited competition for such recognition.

## **IV. New Standards for Community Hospitals**

New standards for community hospitals should build on the solid base of the standards of the Joint Commission on Accreditation of Hospitals and the provisions of state laws and regulations applicable to hospitals. These standards — primarily related to safety and standard clinical process indicators of quality — apply equally to those commercial hospitals or teaching hospitals that have little or no explicit commitment to more cost-effective community health service systems.

These standards were based on the key issues of greatest concern to the public in the 1920's: safety and clinical quality. They do not address current issues of community cost effectiveness, redundancy, accessibility, and quality outcomes. Today, a hospital can meet every legal and accreditation standard without giving any consideration to the community: without knowing the health indices of the community, such as the leading causes of death or disease, or whether the infant mortality rate has bottomed out or is rising. No one within the hospital governing body, medical staff, or management is charged with responsibility for assembling and analyzing basic health indices. In most hospitals today, hardly anyone really knows the facts about illness, disease, and disability in the hospital's community. Accordingly, the typical hospital today does not know whether the services it provides are appropriate, necessary or even desirable from the community's perspective and whether the services, individually or collectively, are contributing to the health status of the community or to the affordability, accessibility and effectiveness of the community's health resources. Few hospitals are able, with any precision, to identify their service community, and the population base that is required as the denominator for any measure of community effectiveness.

These are strong statements; unfortunately, they are true. Today, most hospitals are as backward with respect to systematic approaches to their community health responsibilities as hospitals were with respect to systematic approaches to controlling quality in 1919 when the American College of Surgeons initiated the hospital standardization program.

New standards should address four elements: (a) community mission as a controlling force, (b) commu-

nity linkages, (c) preferential programs for the disadvantaged, and (d) a community approach to quality control.

### *A. Community Mission a Controlling Force*

Like so many new standards, this standard must be initiated with major emphasis on process elements, with outcome elements evolving at a later time. Nevertheless, the standard can be expressed in objective terms, so that compliance can be measured.

The basic elements of a standard related to the hospital's mission are well-known to specialists in organizational development and strategic planning: not only the content of the mission statement, but also the processes by which it is used to guide and control governance, planning, organizational development and management, allocation of resources, and cost containment. Most important, the standard would call for evidence of some form of rudimentary community-focused cost-effectiveness analysis as the basis for allocation of resources, inter-institutional linkages, introduction of new technology, and for downsizing acute in-patient units. Finally, the standard would require a process for evaluating the relevance of the mission in terms of its impact on the various constituencies and communities served by the hospital. Eventually, community surveys should be required.

### *B. Community Linkages*

A community hospital should maintain a variety of formal linkages with a variety of organizations, reflecting the nature of the interdependence required for carrying out the institution's complex community mission.

The standard should call for evidence of formal and informal interaction with (1) various community organizations which can provide input about the community's health problems, (2) various organizations which can support outreach programs in the community, (3) various health service institutions with which affiliation agreements should be in effect in order to assure comprehensive, continuous well managed and accessible care for all patients served by the hospital without unnecessarily duplicating community resources, and (4) contractual linkages with a community financing organization, such as Blue Cross.

In particular, the standard should require evidence of cooperative arrangements with other institutions to reduce duplication of services, particularly in-patient services, and high technology services.

The standard should require evidence of assurance of comprehensiveness and continuity of care through formal networking with other health service organizations, including specific institutions beyond the community, that specialize in care not available in the community.

The revitalization of the community hospital will depend upon the institution becoming an integral element of a community health service system for all the people in the community. At this point in history, a completely autonomous, stand alone, community hospital is a contradiction in terms. A community hospital should serve as a key link between the community and other health and human service agencies serving its community.

Most communities are served by more than one hospital. In this situation, community hospitals are those which are committed to developing networking and cooperative arrangements with other hospitals committed to serve that community. A community hospital serving many communities which are, in turn, served by many hospitals must have an extremely strong and highly developed capacity for networking and cooperative arrangements.

Frequently, in these situations, corporate merger will be the preferable way to assure businesslike inter-institutional arrangements, so long as the linkage with the community interest is not weakened thereby. The unique challenge to the multi-hospital and multi-institutional health care corporation is the creation of an organizational and decision-making framework to maintain visible and viable commitments to specific communities.

In the years ahead, a community hospital will most easily be identified by the nature of its explicit commitments to a larger health service system which, among other things, shares its dedication to its defined community.

### *C. Preferential Programs for the Disadvantaged*

The standard should call for evidence of specific programs and activities directed at those individuals and groups who are not in the marketplace, and who do

not have ready financial access to high quality, cost-effective personal health services.

For the nation as a whole, the uninsured population is currently reported to be about one person in six. In many communities, the ratio is much higher. In addition, people slip in and out of this category from time to time, so that the proportion of the community's population who may be without adequate financial protection against health costs is even higher. Community hospitals will design their programs in relation to the health service requirements of all the people in the community, but will also develop special service and preferential financing programs to the uninsured and other disadvantaged groups. In doing so, community hospitals will enlist as much help from government and other community agencies as possible. For the foreseeable future, however, community hospitals are the institutions through which society demonstrates its capacity to care about this segment of the population.

Such programs will necessarily emphasize primary care and management of a comprehensive care package for each patient, with appropriate involvement of social service.

An explicit standard for community hospitals would spell out in objective terms, the essential requirements of a hospital program for the disadvantaged and would explicitly prohibit inhumane "dumping" of unwanted patients.

#### *D. A Community Approach to Quality Control*

A medical staff appointment at a good hospital has traditionally been the public's best single indicator of the quality of a physician's practice. With the increasing commercialization of hospital service, there is a growing public perception that the public must be protected through outside review organizations, licensing bodies and the courts.

None of these mechanisms will work well, until the public's confidence in the community controlled self-disciplined medical staff organization is restored. This will require a much stronger quality control standard for hospitals.

A new quality standard for community hospitals would adopt a community approach to quality control, as much concerned with medical practice outside as in-

side the hospital, as much concerned with the public's perception of the community's medical practitioners, as with their clinical proficiency.

A community hospital quality-control program would necessarily involve preferential treatment of those community physicians who might be identified as marginally competent; that is, not sufficiently incompetent to warrant action to suspend their medical license.

Based on preferential treatment of all marginally competent physicians, whose practice privileges should be carefully limited and supervised and subject to instant disciplinary action, community hospitals can warn the public of the risks of patronizing physicians who have elected to practice without a community hospital affiliation. Under no circumstances should a community hospital be permitted to withhold a staff appointment from a community's physician simply because he is marginally competent, as is the practice today by many good hospitals.

The community hospital's quality control program would include at least the following features: pre-admission review, medically supervised concurrent peer review, delimitation of practice privileges inside and outside the hospital, an information system dedicated to analysis of practice patterns, patient care conferences with active participation of nursing staff and community agencies, consultation and second opinion requirements, a risk management program and pooling of malpractice insurance premiums, and disciplinary action, with reports to licensing and accrediting bodies as appropriate.

Of greatest importance, the new standard would require the development of a new kind of doctor/patient relationship in which information is fully shared and decisions jointly reached, as recommended by the President's Commission for the Study of Ethical Problems in Medicine.

## **V. CONCLUSION**

In almost all communities in this country today, to paraphrase Winston Churchill, the community hospital is probably the worst possible organization for coordinating and promoting the health of the people — except for all the other available alternatives.

Some may wonder — even assuming that my vision of the community hospital makes sense — whether many existing hospitals can get there from here, or if the transition effort is worth the bother that would be involved. For these, I urge you to visit some of our most outstanding community hospitals, as Paul Starr and I did the other day at the Park Ridge Hospital in Rochester, New York, and study its transformation during the past decade. I remind you of earlier transformations of hospitals in earlier periods, and urge you to think about the frustration, pain, costs, and risks associated with alternative approaches to protecting and preserving the health of the people in communities in the United States during the remainder of the twentieth century.

The only alternatives currently under discussion — a free marketplace approach, massive government regulation or ownership, or corporative medicine — would all be much more painful and difficult, and fraught with many more uncertainties as to the outcome, in the absence of community hospitals.

Theoretically, community HMOs could be conceived of as a preferable alternative, but this is an idea that has never been discussed by anyone, particularly those connected with HMOs today, who expect capitation payment for each beneficiary served. Ultimately, re-awakened community hospitals might well evolve into key elements of community HMOs, or vice versa.

Those who believe that community hospitals can have a key role to play in provision of cost-effective personal health services have a unique opportunity and responsibility for leadership at this time. We must challenge those who might be selectively contracting for services of hospitals: Blue Cross Plans, HMOs, insuring organizations, corporations, unions, and other buyers and government agencies to call for much more than lower costs. Those groups should develop selective preferential contracts with institutions which meet community hospital standards and they should challenge other hospitals to aspire to this goal.

In particular, I challenge hospital trustees, medical staff leaders, and managers of hospitals and multi-hospital systems. I urge their support for the development and adherence to explicit community hospital standards.

I challenge leaders in hospital accreditation and licensure, and of national, state, and local associations of hospitals, physicians, and other health related organi-

zations. These groups can become advocates for a process of distinguishing between community hospitals and other hospitals in all contractual arrangements.

I urge leaders in health service education and in philanthropic foundations to support the development of explicit standards for community hospitals and to support the concept of rewards for those associated with them.

In the original Michael M. Davis lecture, Dr. Davis himself challenged medicine to accept the primary responsibility of the public in deciding how the people will spend their money for health care to bring the full potential of this important service into the lives of everyone. I also stress the key role of the medical profession, but expand that challenge to include everyone associated with contracting for services of hospitals at the community level. The time has come to abandon adversarial relationships among those providers and buyers dedicated to community health service objectives. The time has come to work together at the community level to strengthen the community fabric by common commitment to community hospitals dedicated to optimum cost-effective health service for all.