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Mr. Merrill:

For many years the role of urban hospitals has been the subject of considerable discussion. Their mission, the populations they should serve, their tax status, and even their survival are all issues that have confronted policymakers, politicians, and the medical community.

However, it is important to note that urban hospitals should not be described by location; that is, simply because a hospital is located in an urban area does not necessarily imply that it faces the types of health care problems under discussion at this conference. Rather, when we talk of these hospitals, we should be talking about them within the context of their mission, not location.

As an example, the director of one large urban hospital once described to me the primary functions of that institution in the following order of importance: teaching, research, and patient care. The fact that patient care appeared to take a distant third (there was not even a mention of the hospital's role with respect to its community) appeared to me to represent displaced priorities in the context of defining a true urban institution. In another example, I was once affiliated with an urban institution which did not grant either office space or admitting privileges to its family practice faculty because, in the hospital's opinion, more revenues could be generated using that space for specialties such as neurosurgery.

Thus, within the context of this conference, we ought to be sure that the hospitals we discuss have an urban focus and are not simply located in an urban area. Further, those hospitals should view their primary mission as one that extends beyond the simple provision of medical care and addresses the broader problems of the community they serve.

In addition, the urban hospitals that concern us in this conference are those that serve a broad patient mix. There is a phenomenon in many cities in this country, often called "twinning," where two affiliated teaching facilities may have what could be viewed as a parasitic relationship: these two hospitals, one often being a voluntary institution and the other a public facility, may share an affiliation in the hope of enhancing both the quality of care and teaching program at the public hospital. However, upon examining the "payer" mix of each hospital, one finds a very different type of patient being served. Often the voluntary hospital will have a payer mix that is 85% commercial, Blue Cross, and Medicare, while the public hospital will have a much larger proportion of Medicaid and "self-pay" (read that as bad debt) patients. In the context of the discussion on the plight of urban health care, it is clear which is the relevant institution.

Thus, the hospitals in question can be defined both in terms of the type of patients that they see and the role they play within their community. The problems that these urban hospitals have relate to the fact that the populations they serve have the most complex needs and the fewest resources. In addition, the hospitals must function as more than medical care providers and recognize that the broader social and economic needs of their communities may be more important to the health of their patients than the specific medical problem that presents itself. Whether it is pregnant women, patients with the acquired immunodeficiency syndrome (AIDS), trauma cases, or even more usual medical problems, these hospitals are confronted with a variety of additional concerns, ranging from other, comorbid conditions such as substance abuse to a lack of any social or economic structure for their patients once they return to the community.

This raises another important issue with regard to urban hospitals, one that is not new but is still paid more lip service than real concern: the linkages that hospitals create with other, nonmedical services. In a sense, the health center movement of the 1960s had the right idea in viewing its mission as "multiservice." The centers were not only considered a place where physicians and nurses provided medical care. They would also be a locus for other related needs of the population, including job training, housing assistance, and other social and human services to address the multiple problems they confront.

Unfortunately, in my opinion, the country was not yet ready for such an approach in the 1960s. While in theory we understood the concept of dealing with the person's total needs, the sharp division between medical care and other services, the re-

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sistance of physicians to this, and budget cutbacks over the years made these centers move away from this broader definition of health care.

Today, however, as a nation we may now be more prepared to move in such a direction. As we become increasingly aware of the social factors affecting health, whether it involves pregnant women, substance abuse, or AIDS, the need for such linkages has become more real. In addition, with budgetary pressures at both the state and federal level, there is a growing demand to marshal our resources more efficiently, bringing together the broad range of services necessary to meet the complex needs of the population and to eliminate the duplication and overlap that exist among the multiplicity of programs.

It is important to note that, at the local level, the problem may not be the total amount of financial resources available; rather, it is a problem of how these resources can be used in more efficient and effective ways.

Facilities that can provide a multiplicity of services and can coordinate them to meet the complex needs of the individual are required if we are to respond successfully to a growing demand with diminishing resources. Community health centers, urban hospitals, and even school-based health programs are desired loci for such efforts. Developing these linkages and bringing the range of services to the people, rather than bringing people to the services, must be a priority in the overall mission of a truly urban hospital.

A related issue is that of assuring that the manpower is available to respond to these complex needs. Whether it be nurses in both the hospital and the community who are adequately knowledgeable about dealing with populations with complex problems, physicians who are also willing and able to make use of such linkages, or other related personnel, the urban hospital and other health care institutions must have an adequate, trained supply.

In this regard, a serious concern is whether or not, despite a physician surplus, there will be sufficient qualified doctors to serve these populations. Two issues come to mind:

First is the future of the National Health Service Corps. While efforts are under way to maintain this program in some form, I doubt that many people are really aware of what an important role it has played in the past with regard to assuring sufficient manpower in inner-city hospitals, community health centers, and other programs dealing with the disadvantaged. Unless we can keep the pipeline filled with new physicians under a National Health Service Corps or its replacement, I am not sure how long community health centers, other inner-city programs, and some rural programs will survive. It is easy to justify a decrease in such a program based upon the supposed glut of physicians. It is dangerous, however, to assume that a curtailment of efforts to place physicians in these communities will not have serious detrimental effects on our urban areas. Public policymakers should keep this in mind.

The second issue is that of financing health care in general. Basically, financing drives the health system: not just the amount of dollars spent, but how they are distributed. It is essential that we create the financial incentives necessary to address the issue of manpower supply. How, for example, do we increase the number of physicians willing to practice primary care in the inner city? Current incentives lead to the training of more specialists, rather than primary care physicians (the example of our hospital that would not give privileges to family practice faculty is an indication of how financial incentives work). In addition, during the many years of specialty training, the hospital receives an indirect subsidy. We do not reward the hospital either for training more primary care practitioners, or for placing them, or providing the training in community locations. Rather, we reward them for keeping people in longer to give them more specialty and subspecialty training. We then reward the specialists by paying them more than somebody in primary care. The advent of the resource-based relative value scale may change this, but the effects will be slow. To the current physician coming out of training with $150,000 debt, specialization (rather than primary care) is still viewed as a better way out of indebtedness. It is interesting to note that while only 30% of the physicians in the U.S. are in primary care areas, in most other countries primary care is where the bulk of physicians work. Many of those countries fully subsidize undergraduate medical education. Draw your own conclusions.

Even in programs serving the poor, financial incentives also move away from basic primary and community-based care. For example, Medicaid in most states barely pays primary care physicians for their services. Instead, reimbursement is far better for treatment given in the emergency room or in the hospital clinic. In the future, we must pay more than lip service for these primary care services. Reimbursement decisions must be based on the priority needs of the population and not on protecting the concerns of specific interest groups.

The problems of the urban hospital are not isolated concerns. Rather, they are symptomatic of much deeper problems with the American health care system: inefficient financing mechanisms; little ability to relate the medical with other needs of individuals with complex, chronic problems; and a distorted set of incentives are intrinsic to that system.

We acknowledge the health care crisis in this country, but often appear to address its symptoms rather than its causes. The real issue confronting us is not where to get more money to spend on health care, but how to use the money we already have more efficiently and effectively. A country with an $800 billion health care bill (more per capita than any other nation in the world and more as a portion of our total economy) is already spending enough on health care. Yet, our system can be characterized by administrative inefficiencies, duplication, and inappropriate placement of its priorities. For example, we spend almost a quarter of each health care dollar on the administrative costs of the system. Much of this has to do with the complicated rules for payment, billing, and documentation that characterize our system. Contrasting this to a country like Canada which spends considerably less, probably in the neighborhood of 15%, significant sums of money might be saved. While there is some argument as to the actual magnitude of these savings, there is a reasonable consensus that an improved administrative structure would probably save more than enough money to offset the additional costs of covering the entire population (estimated to be a net of $10 billion to $15 billion).

Another irony of our system is that despite the lack of universal coverage, people do receive care in this country. Poor women do deliver their babies in hospitals, although many may have done it without prenatal care. Individuals requiring hospitalization will ultimately get it, although they may have been able to avoid it had they received earlier, ambulatory treatment. Thus, it is wrong to assume that expanding coverage would necessarily expand utilization. Rather, it might replace a system that often provides care in the most inefficient and often inhumane way with one that emphasizes access to basic primary services and does so providing the individual with more dignity. It is ironic to hear people criticize other systems because of the so-called rationing that exists in those systems. The American system, because of its denial of basic coverage to so many millions of people, actually may ration more care than any other system in the world. The answer does not lie—as some doomsayers argue—in a greater need for rationing; quite the contrary, it will result from assuring greater access to services for our population. Rationing of services only postpones the inevitable; providing services may prevent it.

We have passed through a decade where virtually every approach was tried to address the symptoms of our health crisis. Increased competition and, paradoxically, greater regulation; so-called managed care; and increased cost-sharing for the consumer all were strategies tried during this period.

Regrettably, the total effect was not one of containing costs or increasing access. Instead, the actions of the 1980s led to an increased denial of access to care for many people and, possibly more invidious, the development of an "every man for himself" attitude. Each large purchaser of health care, including the government, private insurance, and large employers, took steps to look out for itself. Rather than developing a system in which the various players worked cooperatively to solve problems, everyone jumped into his own lifeboat which, in the end, nearly sunk all the lifeboats. As we move into the 1990s, the public, private business, and insurance must work together to solve problems collectively. As we should have learned from the experience of the past decade, it is in nobody's best interest to do otherwise.

It has often been said that a country's health care system reflects the values of its society. The fact that the British do not pay for renal dialysis for patients over age 65 is a societal decision, not a budgetary imperative. Society decided to give everyone access to basic health care rather than provide tertiary services to the total population. In the same ways, the Canadian, German, or French systems also have made decisions about what is covered and who provides the services, reflecting the values of those societies.

In each case, different from what exists in the U.S., health care has been judged to be a public good and a basic right for all people. Countries may define differently what that basic right includes, but all have made it a societal priority to assure a level of basic health care for the total population.

In our country, health care is a private good and, despite a debate over the last 30 years, is still not necessarily considered to be a right for all Americans. In my judgment, this is not necessarily a reflection of our societal values, because if it were, then we must be an extremely uncaring, ungenerous, and venal society. Rather, it may reflect some of the historic and economic imperatives that have tended to dominate our health care system.

It is my hope that over the next few years we can stop wringing our hands about the crisis, stop paying lip service to the notion of health care for all, and start to take those basic actions necessary to make our system reflect the true values of our society.

Mr. Roberts:

We have heard throughout this conference about the societal plight of our nation. I hope that the delivery system and our care for the poor do not in fact reflect our society's feeling and commitment to the people of our nation. To this end, we can and must do better.

From my perspective as the Chief Executive Officer of a public hospital, I seriously question the limitations placed upon my institution that restrict our ability to satisfy many community needs which are considered to be outside the walls of the hospital. It must be recognized that my situation, as with most public hospitals, is unique. Charity Hospital of New Orleans is owned and operated by the State of Louisiana but is located in the city of New Orleans. Funding for indigent care is derived totally from state general funds. The City of New Orleans has no obligation to support the operation nor to become involved, even though over 60% of the patients served are from the Parish (county) of New Orleans. There are eight other hospitals within the system and they are located all over the state. Charity Hospital of New Orleans is the tertiary referral center for the system. It takes all of our available resources to fulfill this responsibility to the smaller hospitals, as well as to satisfy the needs of our local patient population. Any program to provide services outside the hospital would require prior budget approval. To the extent that this would be considered to be a responsibility of the City of New Orleans, such approval would be withheld by the state legislature. As the major provider of indigent health care in the city, we are the logical resource to satisfy the gaps which exist in the health care continuum.

All is not lost yet. The City of New Orleans is currently attempting to develop a coalition to assess the health needs within the city. At one point there was skepticism expressed by a few of the private hospitals when asked to participate in the planning process. When explained that it was an opportunity to begin to harvest the limited resources, both public and private, to deal with the problem of indigent care so as to maximize the total effectiveness of the outcome, they eventually bought into the plan. The fact that federal funding to support the effort could be made available was certainly a factor in the willingness to consider cooperation.

We have heard in this conference about the problems of the uninsured and the experimental programs being considered. Many of the insured are in fact working, albeit for small businesses. These entities, especially those with fewer than 10 employees, cannot afford to pay their employees a meaningful salary and at the same time provide them with an adequate level of health insurance coverage. Moreover, this population group most often will not be able to qualify for the Medicaid program

and yet cannot afford the high cost of medical care. Several of the demonstration projects have determined that it is possible to establish programs which will provide coverage through employer pools working with insurance companies at rates that are affordable and with coverage that is adequate. We need to develop this concept more broadly. The one critical factor contributing to the success of these plans was the lack of a federal mandate. They were coalitions developed around a voluntary structure for the purpose of satisfying a real need. This approach needs to be pursued and the model duplicated.

In toto, all hospitals, public and private, need to reassess their missions in light of the communities they serve so as to be certain that they are satisfying the real need of the communities with the resources available. Moreover, there is the need to become involved in the community in order to have them know who you are and to have them be an active part of any program you develop to improve their community. In developing the mission statement, it must be actively pursued and not merely a paper document.

Sister Heid:

I want to offer random thoughts on health care reform, some of which come from my experience on the National Leadership Commission on Health Care. First of all, I am convinced that "The Plan" has not yet been written. We may adopt some form of the Canadian system, a modified Pepper Commission proposal, the American Medical Association plan, the Stark plan, or one of many others. The estimated high cost of these plans has been widely cited. However, most of the 33 million uninsured/underinsured people are now receiving some care. Granted, their care is neither sufficient nor timely, and thus these people eventually need high-intensity, high-cost care. The estimated cost of the proposed plans should take this into account and not assume that it would be all new money spent. In any event, the most important aspect of any plan adopted will be quality control or continuous quality improvement. If 20% to 40% of the care currently rendered is unnecessary, inappropriate, or harmful, as has been reported, we need to improve the quality aspects of appropriateness and necessity and reallocate our money.

In any plan for reform the debate will center around mandating benefits, especially for employees of small business. The word "mandate" sends shivers up the spines of small business employers. Any reform proposal must carry clear definitions of what is meant by such terms as a basic benefit package, a global budget, an understanding of limits, the balance in the plan between competition and regulation, and how long-term care is addressed. Some people think that a single rate will be the current Medicaid rate. They support that, of course, because it is very low. Unfortunately, when it comes to the level of a single rate for health care, many people are uninformed about health care payment and the need for adequate rates for providers.

Change in our health care system is likely to come gradually, and the first changes will probably come in financing and then in delivery. It is easier to change financing through legislation which can be targeted at hospitals, physician payment, or outpatient payment. Changing the delivery system is more complex, because many institutions and many more individuals are concerned, such as physicians, nurses, therapists, and other caregivers, all of whom have professional traditions to maintain and whose care for individual persons will always take priority over observing governmental rules and regulations. Delivery organization changes will take place mainly in response to payment requirements and financial incentives. While some change is voluntary—doing things because they are the right thing to do—such change is hard to find on a sustained basis. Dr. Jack Geiger left most of us very pensive, pondering the nearly overwhelming task of reforming the social contract. "Pessimism is no reason for inaction," said Dr. Geiger, "and broader social change must take place, even if piecemeal."*

We need fundamental shifts in the mode of health care delivery. The outreach by health care institutions is encouraging in nursing care, after-care, and hospice. We really need more "before-care," health promotion, wellness, safety, and primary care in mobile clinics. In the company of one of our home health care nurses, I recently made five home visits in about 5 hours. We traveled 120 miles. It is a wonderful service, but how efficient is it? When we returned to the office, the nurse still had two hours of paperwork to do for the Medicare patients. Perhaps we might adopt a concept that is working for us in the rural outreach program. When a nurse goes out, she does not provide care but makes linkages with other agencies. She can see a lot of people, assess their needs, and link them to the appropriate agency. Many patients do not know how to access available care. In the parish nurse or church nurse program, we have discovered that many retired health care professionals are willing to assist an elderly person or a family without other support.

We all need to be more adept at partnering, collaborating, and being advocates and catalysts. We cannot be paralyzed by the task ahead. We must courageously enter into the ethical debates about limits. We need better philanthropy and fund-raising efforts and techniques.

In health care, we must reconsider some of our assumptions. What if payment were shifted drastically from acute care and elderly care to outpatient care, ambulatory care, and to children? What if the physician were not the gatekeeper, but another professional became the gatekeeper? What if we really maintained people out of the hospital, in their homes? What if capital were given not for buildings and technology but for programs and services? What if urban blight and ugliness were turned into livable neighborhoods? To paraphrase an old proverb, "We cannot be about this new thinking too soon, because we never know how soon it will be too late."

Audience Question:

Sister Heid, would you respond to Mr. Merrill's comment regarding the nursing shortage or shortage of personnel because of expanding roles and whether or not care is being taken away through the expanding roles?

*Geiger HJ. Urban health care and the social contract: Poverty, race, and death. Henry Ford Hosp Med J 1992;40:29-34.

Sister Heid:

I agree that many of our health care professionals, including nurses, are not deployed correctly. We still have a shortage of nurses in Iowa and other areas in the country, but it is a problem of maldistribution. I do think there are ways to motivate nurses and other health care professionals to think differently, to take more responsibility for their profession, to get over the feeling and belief that they are, perhaps, second-class citizens. We have a program in our own corporation whereby we are restructuring nursing and having nurses take more responsibility for their own activities. The key is for nurses to consider themselves a valuable member of the multidisciplinary team which is becoming so important in every setting, not just in the hospital or in the community health care centers but also in the home.

Mr. Merrill:

I think the issue is twofold. One is that we should expand the role of the nurse. There are some very successful models that are being developed in health systems around the country. But while we're doing that, we should be "backfilling": as we expand that role, we should have other personnel filling in at the lower end. So, in other words, the nurse isn't moving in both directions; she is moving up in her role. The National Commission Report estimated that the role of the nurse had expanded by about 20% or 40%. And it wasn't 20% or 40% in the right direction. It was 20% to 40% in the other direction, towards the licensed practical nurse, the nurse's aide area of responsibility. The conclusion could be that you either replace that 20% with lower-level personnel or you increase the number of nurses by 20%. It seems to me the answer was obvious, except the Commission seemed to have reached the wrong one.

Mr. Roberts:

My comment will relate to the findings of the Secretary's Commission on Nursing which dealt with the nurse shortage. It was determined that 80% of the registered nurses were employed and that 70% were employed in hospitals. In regards to the utilization of nursing resources, the Commission recommended "that health care delivery organizations should adopt innovative nurse staffing patterns that recognize and appropriately utilize the different levels of education, competence, and experience among registered nurses, as well as between registered nurses and other nursing personnel responsible to registered nurses, such as licensed practical nurses and ancillary nursing personnel."*

Charity Hospital of New Orleans, because of the gross limitation of available registered nurses, is presently maximizing its use of licensed practical nurses through training and upgrading of skills to minimize the impact of the nursing shortage.

Audience Question:

Mr. Merrill, we've heard many reasons at this conference why the urban hospital, despite declining occupancy, has an important continuing role in the community. In the section of your discussion about supply issues, you didn't mention the problem of too many beds. Do you have any comments about that particular issue?

Mr. Merrill:

You have to remember I'm from the East, and in urban hospitals in the East we have the opposite problem: we have too few beds in many places. Occupancy rates are up at 99% or 101%. So accept my Eastern bias on that. The AIDS problem in New York City has created a situation where, if it continues, there won't be any other medical-surgical beds left in hospitals. I'm not saying that's actually going to happen, but it is the direction in which these hospitals are moving. So I see the problem as being not too many beds but too few beds. My sense, though, is that in other areas of the country the problem of too many beds has been around a long time and cannot explain the recent growth in health care costs. Clearly, in the East, we've solved the problem. We solved it too well in the 1980s. The question I'd raise is perhaps we have too much staff. For example, the average hospital in America has 4.8 staff per bed. The average hospital in Europe has 2.5 staff per bed. Perhaps the answer is 3.5 staff per bed. However, if you consider labor costs to be about 70% of hospital costs, there seems to be some opportunity there for reducing dollars.

If I were in the West, I might have the viewpoint that it seems important to decrease the number of beds. But too many beds doesn't seem to be what's driving the cost. It may be the staff per bed, or the use of those beds, or just the shift of payers within those beds.

Mr. Roberts:

When considering the ratio of staff per bed, it is important to consider not only how the staff is utilized but also the makeup of the institution. For example, in Charity Hospital which has 600 beds, you have to look at the staffed beds, not just the licensed beds. You also have to look at the utilization of those staffed beds and the relationship of the inpatient activity to the outpatient activity, because that staff is spread across the board in terms of the hospital. We have 500,000 outpatient visits and it makes a difference in terms of how that staff is deployed and how that ratio is counted. In my opinion, the ratio of staff per bed is not important until you take into consideration the specific makeup of that particular institution.

Audience Question:

I represent a suburban hospital where we have few Medicaid patients and less than 50% Medicare patients. Our problem is that we would like to find ways to help the urban hospitals, but we don't know how. Our hospital is approximately 15 miles away from the city and there really is no bus system that could even help the patients reach us. We want to try to bring help to the city, where the problems are, but we don't know how. We can't simply donate money because, as part of a system, much of our revenue goes to a system office which is shared with some of our urban hospitals. Mr. Roberts, you talked about collaborating

*Secretary's Commission on Nursing, Final Report, Vol I, December 1988.

with private hospitals. Do you have some ideas of what we can do to start such a collaboration?

Mr. Roberts:

It is important that we look at our own arena and determine what works best for us there. We can't each do what everybody else has done, and we shouldn't even try. You need to assess your own area and look at your own resources, including other hospitals and other health care providers. Then decide and determine, collaboratively, how you can combine your resources to deal with the specific problems within your area.

Sister Heid:

A good example is the collaborative effort of the Catholic health systems in Michigan. Six Catholic systems serve in Michigan but not all of them serve in the inner city. We came together as a group of systems and decided that we didn't need to do one more assessment of human needs, because we know the human needs that are not being met. We decided to do a small study to determine why the infant mortality rate in Detroit is three times the national average and why it's higher than that of many third world countries. Our interviews in 1986 revealed that the highest correlate of women not seeking prenatal care, or not staying in a prenatal care program, was low self-esteem. The highest correlate with low self-esteem was found to be illiteracy. Therefore, we developed literacy activities as a component of this project, which is an award-winning program. In response to the findings of our study, we developed a collaborative program in Detroit, funded by the systems, with the project staff raising matching philanthropic funds each year. We don't have a big success story yet, but we have more than 50 babies who have lived more than one year and whose mothers have been partnered with other mothers who have helped them improve their self-image and eliminate their need for drugs, alcohol, and cigarettes.

Audience Question:

Sister Heid, what would happen if the physician is no longer the gatekeeper? What if these other health care professionals had privileges in hospitals to return to the system of health care rather than the acute care model?

Sister Heid:

It is one of the "what ifs" that I hope happens and is consistent with the need for change or reform of the delivery system. I think there are enough physicians who would not be threatened by that concept. It seems to me that the multidisciplinary team concept is currently the most favorable—everybody helps manage the patient and each member of the team is equally important. Seeds of that concept are already working and hopefully it will grow. Much will change in the physician community when women physicians outnumber men physicians. That will happen, and women will eventually outnumber men in upper level health care administration roles as well. In 1968, I was the third woman ever in the hospital administration program with the University of Iowa. Today, women are the majority in hospital administration, and I think that's true in most programs. It is true that many women in hospital administration start out in staff roles, as consultants; they don't jump into the line management that might lead them to chief executive officer roles. But I think that will happen, maybe not as fast as the physician change, but it will happen.