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PLANNING FOR FUTURE RESOURCES

(Remarks by Paul D. Ward
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About one hundred years ago, Alix De Toqueville, noted French scholar and writer, in his observations regarding life in the United States, wrote:

"Americans of all ages, all conditions and all dispositions constantly form associations - The Americans make associations to give entertainments, to found seminaries, to build inns, to construct churches, to diffuse books, to send missionaries to Antipodes; in this manner they found hospitals, prisons and schools....."

Hospitals, which required this kind of collaboration one hundred years ago, are perhaps the best example of the cooperative arrangements in our present day society. The growing sophistication of our voluntary and university based medical centers is an outstanding example of the capacity of a pluralistic society rooted in an expanding technology. The miracles of organ transplantation, megavoltage radiation therapy and cancer chemotherapy were only fantasies in the age of De Toqueville--yet they are the most popular subject of commercial television today; exposed to the young and old, the rich and the poor, and they are part of everyday conversations.

The success of the American hospital system has indeed been spectacular and has paralleled the success of the advances of the science of medicine. Nowhere has this been more evidenced than in the accomplishments of American surgery. Incorporation of the advances of basic physiology, pharmacology and biochemistry has extended the hand of the surgeon so that he has been able to bring these miracles of modern surgical practice into the remote hamlets of the United States and on to the fields of battle.

Yet, it is the very success of the research and development of modern medicine that threaten the advance of our medical care system. The expectations of the consumer of these services may well be on the way to outstripping the capacity of the system to provide the services that are declared to be a basic right of all citizens of this country.

The health care system in the United States has become a subject of great national discourse in the last few years. Lay and professional groups devote large amounts of time to praising and condemning the quality and quantity of the medical care that is available to their constituencies and in exercising their right to influence the direction of the health care system of the future.

Representative Mills, Chairman of the House Ways and Means Committee, has recently estimated the health expenditures for fiscal 1970 at almost \$70 billion, which is 7 percent of the gross national product. Mr. Mills said that the health care figures point out two major characteristics of the health industry - "rapidly escalating costs and rapidly increasing public demand."

Although the practice of surgery has been traditionally surrounded by mystique and glamour, and the provision of such innovative procedures as organ transplantation have received great public support, planning for the future will necessarily be controlled by the urgency of cost containment and the demand for more equal distribution of high quality surgical services. The problems of our deteriorating central cities and abandoned rural communities will become more pressing as our shifting population and attending social problems threaten the very existence of our current structure.

Although much of the increase in costs and the disparity of distribution of our health care resources has been blamed on the supply of health manpower, it is obvious also that much of the problem must be blamed on the character and distribution of health facilities. In one city, there are about thirty pump oxygenators for the performance of open heart surgery. A recent survey indicated that 90 percent of the cases in this community was done in five of these facilities. There is reason to believe that many of the other facilities were not only under utilized to the extent that costs of other hospital facilities were strained, but that there was inadequate experience to protect the safety and welfare of the patients who were subjected to surgery at these facilities.

The concept of health facilities planning is rooted in ancient history. Centers for the treatment of categorical diseases were well established in the beginning of modern history as societies began to marshal resources, first to segregate the ill, then later to provide

the benefits of the expanding body of scientific knowledge. More recently, our affluent society has markedly altered the concept of inpatient care, and in many instances, we suggest that this has not been to the benefit of the patients whom we claim to serve.

Certainly, we see the need for involvement of a variety of skills in planning for future resources. We have been asked to comment about the role of a team in planning for future resources - the surgeon, the administrator and the trustee. To this team we would like to suggest a fourth very important partner - the public, or those who represent the public interest. The public interest spokesmen have been too often oversimplified when called "consumers". Not all consumers are interested or qualified to participate in the important decisions of health planning. But the interests of all groups, provider and public, must find adequate expression.

It has been estimated that the total body of knowledge has doubled in the last twenty years, and that it will double again in the next ten years. This quantum jump in available knowledge has been spectacular and demonstrable in the field of medicine and perhaps more dramatic in the special field of surgery. Less dramatic, but very important, have been a number of other fields of interest which are related to medical and surgical care. Epidemiology, demology, transportation, high-speed freeways, and advances in the internal combustion engine, have all had their impact on the demands for surgical care. Advances in radiologic techniques, immunology, cancer chemotherapy, nutrition, and automation have impacted upon traditional surgical care.

Rational and coherent planning, based on firm data and on competent professional surgical advice, must be the basis of planning for future surgical resources. Manpower, bricks and mortar, equipment and services must be provided to the consumer in a manner which is accessible, acceptable and available to the consumer of surgical services in a form which represents the highest quality that is available by the provider of these services. This will require a collaborative venture of all those who are involved in such services.

Questions such as these sooner or later must be faced.

What about:

- Accessibility - Has consideration been given to the location of the service in terms of 1) those who will use it, 2) services related to it, and 3) where it can be performed most effectively and efficiently?
- Financing - Is it provided in a setting where the maximum coverage is available and the most economical delivery is possible?
- Quality - Does the service lend itself to quality comparisons, peer review, objective control and audit?
- Organization - Does it complement the system as a whole, tending to create a single system with a single level of care?
- Resources - Are the manpower and facilities balanced--are they each obtainable concurrently or within reasonable periods of time?

- Acceptability - Is the service organized in such a way as to gain the greatest acceptance by the patients?

These are some of the questions that should be considered when developing any medical service.

Least understood and recognized is the hospital trustee. Hospital trusteeship is at times a complex and time-consuming job, financially unrewarding and frequently involving great personal sacrifice. The trustee is usually selected because of a contribution which is expected from him, either in money or in expertise. He usually does not meet the physicians who practice in the hospital and seldom knows the patients whom he serves. Generally, he is chosen because he has been successful in his field, yet he is relegated to a position of support for the administrator or the practitioner.

In this regard perhaps we should look at our health care efforts in their totality. Some claim we have a "health care system"; others claim we have a "non-system". If we strip the argument of its emotionalism, it seems we have the beginnings of a system, but that we are weak when it comes to consideration of the management capabilities.

It seems that if this nation's health care delivery efforts are to be categorically defined as a system or systems, the major component that must be developed is management structures over given geographic areas. Although areawide planning agencies exist for described geographic areas, management capabilities necessary to take the next step after planning,

i.e., to put the plans into effect in an effective and efficient manner, rarely exist. Perhaps planning units should explore the creation of health management units over given geographic areas which would be concerned with the services rendered by all facilities in the area. The management unit could take a variety of forms, i.e., a board of directors or commission with staff composed of a mixture of providers and the public, who would basically be concerned with directing the quantity and quality of services rendered, the hours they are available, and generally to see that the community's health goals are achieved in the most expeditious manner.

De Toqueville might call this one more set of associations. Whatever they might be--associations, non-profit health corporations, councils, or commissions--logically they are needed to balance--and make complete--our concept of a system.

Planning for the future must be the consensus of all the involved groups. The surgeon, the administrator, the trustee--and the informed public. Technical services of other knowledgeable groups must be used. The complex problems of the medical care system of the future will require input of a variety of skills which will contribute to rational and realistic planning with a realistic means of implementation through some form of system management.

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