This paper deals with a variety of problems that arise when a public agency tries to innovate in the provision of health services. These involve bureaucrats, hospitals and their officials, community groups, and health professionals. Mutual dependencies and changes in power relations are assessed.

ENCOURAGING GROUP PRACTICE: WITH GUN AND NET THROUGH THE HEALTH ESTABLISHMENT

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While living through the experience of trying to establish prepaid group practice as a state health department employee, the author frequently felt that he was on a safari through a jungle where the natives were not friendly, the animals were scarce, and at times it was difficult to tell the hunters from the hunted. Symbolically, who has the gun or the force to order that change be made in health care delivery? And who has the net to keep parties trapped in agreement?

What follows is a description of the problems that arise, specifically and generally, when a public health agency attempts to bring about change in the way medical care is made available to a segment of the community. This paper will not just be a discussion of the Baltimore situation but will elaborate on some attitudes and postures of groups in the broad public health arena.

In 1969, the Maryland State Department of Health and Mental Hygiene decided to encourage the establishment of prepaid group practices by hospitals and other groups. At the same time, a large university teaching hospital began to develop the idea of a group practice to serve the community in its vicinity. A community group worked with the hospital to implement this idea. In addition, two other hospitals started working with the state to establish new patterns of delivering medical care to persons who reside in the communities immediately surrounding each hospital.

The state government planned to finance these innovations out of Title XIX funds, since no other monies were available. Unfortunately, this limited patients to those eligible for Medicaid. It was also hoped that an arrangement with Medicare could be worked out so that persons over 65 could be cared for as well.

The three communities served are located in the inner city of Baltimore in three distinct geographic areas that have the same common characteristics. These areas have experienced rapid change in racial composition and a steady decline in the number of private practitioners. Persons in these communities wishing to receive medical services must, in most cases, travel to see an already extremely busy practitioner or go to the crowded outpatient facilities of a hospital in the proximity. Most patients choose to use hospital outpatient departments.
Since private practitioners throughout the city were very busy, and only a limited number saw many Medicaid patients, it was not desirable to concentrate on efforts to involve these professionals. However, official contacts were made with professional groups. Although it was made clear that innovations in ways to provide care would be welcome from them, none were forthcoming at the time.

These were the prevailing conditions which the state decided to deal with realistically by financing new methods of delivering health care based on Medicaid payments to hospitals. It was recognized that persons who sought care did so from hospitals where the present costs to the state were very high and were likely to get higher.

A new state law allows for the pre-paying of providers of care. The providers have to guarantee that a specific array of services will be offered to a defined population over a period of time. Prepayment allows the state to know precisely how much money will be paid out ahead of time. In addition, it was decided to derive prospective cost figures that would be used as the basis for payments. The hospitals welcomed these suggestions giving them operating money prior to the rendering of service instead of afterward.

Prepaid costs were to be calculated in the following manner: The letter x is used to represent the total number of persons eligible for Title XIX, Medicaid, in the state in a past year. Utilization figures were derived as follows:

\[
\text{Total ambulatory visits statewide paid by Title XIX} \times \frac{\text{number of visits per eligible}}{y}
\]

\[
\text{Total inpatient visits statewide paid by Title XIX} \times \frac{\text{days per eligible}}{z}
\]

The utilization figures arrived at in this crude manner were used without an attempt to adjust them to local conditions. Cost figures used were simply the Medicaid rate paid in a particular institution. Since it was deemed desirable to use the prospective costs, the existing Medicaid rates were readjusted upward to show the expected increases in cost within a specified time period.

Expected increases come from escalation clauses in union contracts and estimates of increases anticipated due to technological change. For example, to arrive at the amount of money the state would be willing to expend per individual, the sum of \((y)\) times the estimated cost of an outpatient visit, plus \((z)\) times the cost of an inpatient day, plus the cost of any other Medicaid reimbursable services equals the total annual figure available for prepayment.

This figure is admittedly very high since it includes days of care for the medically indigent who are already in the hospital when they become eligible for Medicaid. The amount of money the state was willing to prepay per individual for a 12-month period was between $225 and $290 depending on which services were included and the anticipated labor increments.

This money was to be used in the following manner by a hospital. An individual hospital was encouraged to set aside or acquire space, preferably outside of its own building, which would be a group practice health center. In this facility would be as many physicians and other health workers as are necessary to serve a defined population who are specifically enrolled in a prepaid health plan. A community organization complete with a board and other indigenous people would be needed to plan and staff the project, publicize it, and encourage families to enroll. The hospital would have the responsibility for the initial expenditures to plan and recruit professional staff for the center. The total resources of the hospital would...
serve as a back-up for the professional activities of the center. For instance, needless duplication of x-ray equipment would not occur since radiological services are available in the sponsoring hospital.

All patients would be hospitalized in the hospital under the care of a physician from the health center. Specialty services would be provided by members of the hospital’s staff, either in the center or in the hospital outpatient department. The sponsoring hospital and the health center medical staff must work to minimize inpatient utilization by providing comprehensive ambulatory health services to a family group on an ongoing ambulatory basis. The savings resulting from the lower use of hospital beds could then finance more services at the center. Care given in the center would not be merely an extension of the hospital emergency room and outpatient department. A patient with a chronic disease or with a need for follow-up care would not be left to seek care on an ad hoc, catch-as-catch-can basis. Record systems would be set up to coordinate with the efforts of family health visitors so that there would be supervised follow-up and follow-through on the part of both the patient and the medical personnel.

Individuals eligible for services (initially this meant Medicaid eligibles only) must agree to enroll for a specific period of time in one of the hospital-centered group practice plans. The enrollee must be thoroughly familiar with the plan, how it will work, and what his responsibility is. For a specified period of time, he must agree to receive all his medical care from the plan and not go elsewhere when a service is available in the center. In case of emergency, he is to come to the emergency room of the sponsoring hospital when that is the most convenient facility for him; otherwise he may use any hospital or individual physician. Payment for emergency services rendered outside of the affiliated institution are to be paid for by the center, not by the state Medicaid agency.

The state agrees to pay the hospital sponsoring the group health plan on the basis of enrolled patient months. That is, no payment is made for less than one-twelfth of the year’s prospective rate. The state also agreed to pay $10 for each enrollee at the beginning of the program, up to a specific number, to help defray start-up costs. By making payments prospectively a hospital could plan staffing and other arrangements ahead of time.

Incentives

It was believed that this new method of payment would be an incentive for good medical management of the group practice. It would be clear to all participants that the savings resulting from efficient practice and low inpatient utilization would permit monies to be accumulated. The state built in an incentive toward the economical provision of services by allowing the participating hospital to keep 50 per cent of any surplus accumulated for use in improving care provided by the group practice. On the other hand, if a deficit was incurred during the first year of operation, this deficit must be paid off out of the hospital’s share of any surplus accumulated in succeeding years.

The Various Parties

This description of the administrative arrangements serves as an introduction to the setting of this safari through the health establishment. Now it will be shown which parties have the guns or power to force change and who has the net to keep people trapped in agreement.

First, there is the federal government which is putting up the money for at
least 50 per cent of all Medicaid expenditures. Second, there is the state government through which funding is to come and which encouraged the idea in the first place. Third, are the participating hospitals with the various factions within them. Fourth, is the community to be served. Within each of these parties there were widely divergent opinions and many of these opinions changed over time.

The Role of the Federal Government

The federal government has issued statements sponsoring the encouragement of group practice. Secretary Finch, in March, 1970, came out strongly in favor of “neighborhood health centers, outpatient facilities and other facilities designed to reduce the need for high cost hospital services.” He asked for the authority “to enter into health maintenance contracts guaranteeing health services for the elderly and the poor at a single fixed annual rate for each person served.” To these ends, a model agreement or contract was worked out by the Maryland State Department of Health and Mental Hygiene and the participating hospitals. This agreement or contract in draft form was submitted to federal regional officials. With very slight changes it was approved.

It is interesting to note that federal officials did submit this contract to persons on their legal staff who condemned it for containing just those innovations that the secretary had called for. These opinions were disregarded. The federal government has the ultimate authority over how Medicaid funds will be used. If less progressive federal officials or some more in tune with their own attorneys had been in positions of authority at the regional level, the whole idea might have been killed.

The Role of the State Government

The state government, despite its role as the instigating and sponsoring agency, cannot be thought of as a monolithic organization positively in favor of establishing a prepaid group practice for inner-city indigents. At the highest levels, this was pretty much the attitude. Lower down through the state government there was little opposition stated clearly and directly toward such a scheme; objections to innovation were made in a more subtle manner.

One could not help but get the impression that there was a certain amount of resentment on the part of state employees toward this plan which they saw as a massive giveaway on two counts. First, they were not happy with the idea that poor people should get more and better services that would be paid for out of the employees’ tax dollar. Second, they were not enthusiastic about putting more money into the teaching hospitals which they see as fat recipients of state funds. State employees do not believe that these hospitals are in as shaky a financial condition as the hospital directors perpetually claim.

In order for group practice plans to start, a formal contract had to be developed between the state and a hospital, and the state had to adjust a number of mechanisms that function for Medicaid patients in order to accommodate these plans. The contract was worked out at several levels in state government and with physicians and administrators at the hospitals. When a mutually agreeable document was created, it was sent to the federal government for unofficial approval. This same document had to be approved by the state attorney general and the hospital attorney. Approvals reached at the top levels were often questioned by lower level employees who felt that they had the right to hold up the document for technical reasons. Often these negotiations took on a round-robin appearance, as previously settled issues kept coming up again.

A number of problems arose when
it came time to get down to the details of adjusting the presently functioning state Medicaid mechanisms. All Medicaid eligibility is handled by the state and city social service agencies. Their information is kept on file in computers that issue Medicaid cards. If a small portion of these individuals are to receive services which are to be different from the vast majority of card holders, there are a number of changes that must be made in the system. For example, a special card must be issued to individuals enrolled in a group plan. Therefore a social worker must be assigned to the health center to work on enrollment problems and to integrate the two systems. In addition, there must be agreement as to which statistics are kept by the hospitals and which by the state, both for local use and for reporting to the federal authorities.

It was apparent to all concerned that the program was to start immediately. Often, however, it was not clear to those lower down on the ladder of officialdom who was going to accomplish the actual task of changing the system. There were few individuals capable of performing this function in the bureaucracy, and those who were already there had sufficient work to do in their presently assigned positions.

In summary, the state government was the coercive force bringing the parties together for innovation. It also had power—Medicaid dollars—to see that these innovations were implemented within a framework allowed by federal authorities.

The Role of the Hospital

The hospitals have great difficulty adjusting to their new role as participants in providing services to a community—a community which also has an input as to how these services will be provided. Until very recently, hospitals did not have to deal with the basic wishes, expectations or demands of the great bulk of patients whom they purported to serve. Hospitals had the power to remain aloof.

It is frequently said that the first responsibility of a university medical center is teaching. Because teaching is the stated goal of many hospitals, conflict often develops between those outside the hospital—who have expectations as to the type of care they think they should receive from the hospital—and those who believe are in authority to provide this care. Within the hospital, strains occur between those who wish to offer a pattern of services different from what presently exists and those who feel that this will interfere with the preservation of educational excellence.

Most teaching hospitals are not staffed, nor are they temperamentally suited for the provision of routine family medical care on an ongoing basis. The personnel in these hospitals are interested in making difficult diagnoses, and in teaching the science of medicine to medical students and house staff. Had it not been for the demands of local consumers and the interest generated by astronomical hospital costs paid for out of public revenue, it would have been some time before teaching hospitals would have done anything but continue to become more scientifically excellent, growing ever more removed from providing routine medical care. Furthermore, as specialization became the goal of teaching, the teaching hospital gradually dissociated itself from the general practice of medicine in the community.

When a teaching hospital begins to interest itself in the provision of routine medical care, it first sees that outside funds are available to support these new activities. Then, to assure that high quality care is going to be provided, it is established that patients are only to be treated for their illnesses by specialists of the appropriate specialty. The
problem with this is that it in no way insures comprehensive high quality and consumer satisfaction on a day-to-day basis. Specialists are interested in treating their part of the whole, and it is difficult to care for the integrated total patient in this setting.

Virtually no general practitioners are being trained in university medical centers, and those young physicians who are interested in general practice do not become associated with teaching-hospital-sponsored group practices. Since there really is no university-approved general practitioner at present, a board-certified internist is selected as the man who should be the primary care physician for adults. There must be an obstetrician-gynecologist available. A pediatrician is mandatory since an internist rarely looks at any possibly normal human being under age 17, and no pediatrician will look at anyone over that age in other than an immediate life-threatening emergency.

Once this team is formed, who is to be the captain? Which doctor is to be medically in command in a teaching-hospital-sponsored group? Will the pediatrician bow gracefully to family-centered care rather than child-centered care? Will the part-time surgical consultant quietly step aside when the internist feels that an operation is not necessary? In a properly managed group practice, one physician is truly his brother's keeper. Will men who are used to the "come back tomorrow" attitude of the emergency room toward the "crock" be willing to serve the needs of a patient in a more comprehensive way, no matter how annoying or demanding the patient may be?

Another problem faced by the teaching hospital is the staff's assumption that they have all the expertise necessary to establish any new health delivery system. Clinically trained physicians frequently feel they are the most qualified to plan and run a prepaid group practice, despite the fact that they have little or no training or experience in planning, organizing or managing. Today, in the United States, there are few people from any background who do have this ability and experience in health services. The physician's assumption that he knows it all, ipso facto, merely complicates things further.

The hospital is the one possible source of personnel to staff new delivery systems. It has enormous power because it is always open and always capable of supplying emergency medical services. A hospital's reluctance to use this power to change the delivery system is encouraged by the various splintered interest groups within it. This truncation of power within, coupled with the presently existing economic realities, fosters the hospital's reluctance to innovate. At this point it is pertinent to examine the role of the community in relation to the nearby hospital which offers services to it.

The Role of the Community

The various segments of the Baltimore inner city community suffer from the same problems found in other big cities. In the area of health, Baltimore has a number of fine medical institutions, almost all of which have a past history of overt racism. Members of the communities surrounding these institutions view with great skepticism any attempt by the institutions to serve the community.

While many changes were taking place leading to the equality of all citizens, the medical institutions in Baltimore remained aloof from the communities surrounding them. The people were free to use the emergency room and outpatient departments as they wished, but there was little attempt on the part of the hospitals to try to accommodate the needs of these people. The hospitals were content to have the people remain
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an excellent source of teaching material for their educational goals, although, after the riots of 1968, more concern with service to one's neighbors became a topic for discussion.

Of course there are bound to be some major sources of conflict when a community group and a hospital start to jointly plan and ultimately administer a group health facility. Some of the intrahospital conflicts discussed earlier are heightened when pressure is exerted from the outside. While the usual platitudes are expressed by community persons and others that there is no desire on the part of consumers to control the practice of medicine, the hospital and its physicians find themselves questioned and challenged in many areas where no one has dared tread before.

This does not mean that the community is interested in influencing a physician's choice of a drug dosage of one milligram rather than two. It does mean that a physician is working for a group of consumers who may find fault with his attitude and have the power to remove him. There is a real danger that a physician may act in his usual manner toward a patient—a manner that can be interpreted as a lack of insight and understanding toward the type of patient being cared for. The community may be under the false illusion that private patients have a universal feeling of satisfaction about the attitude of their physician toward them. When such misunderstandings are complicated by the fact that the various parties are of different races, a very unhealthy initial relationship may be established.

The state of Maryland made it clear from the outset that the Medicaid monies were going to be paid only to established providers of care—hospitals or practitioners. In the beginning there were those who saw the establishment of group practices as a means of getting money into the community; they felt that the control of this money would change the scene as it presently exists. However, when speaking of the provision of health services, this is unfortunately not the case—the main obstacles being the over-all shortage of physicians, and an absolute dearth of physicians willing to spend full-time careers serving inner-city populations. With all the best paramedical professionals one could ask for, it might be possible to improve the public health in an area, but one cannot expect to receive high quality medical care without an ample supply of physicians.

The interest expressed by medical students and others in providing medical care to indigents may bear fruit in a few years. At the present time, however, inner-city teaching hospitals are even finding it difficult to fill previously sought-after internships and residencies. Therefore, when a community group sees itself in the position of controlling its own medical services, it had best be wary of the amount of control that it is capable of exerting. If a community group does not control its own rhetoric, and if professionals operating in the new health setting in the community start to feel threatened, there are not going to be the required number of physicians and other health professionals available after a few months of operation. Community power to control may be fine as a concept, but chaotic community administration will not lead to the so earnestly desired result.

Conclusion

This paper has described the various problems that arise when a public agency tries to bring about innovation in health services. Parties frequently are not in agreement and have to be coerced or netted; they have to be shown that certain attitudes and postures are now archaic in the light of the present social and economic situation.

The reluctance of a bureaucracy to be
an instigator of change was explored from the bureaucratic inside. Here, the gun alluded to in the title might occasionally be used to force officials into agreement. Although hospitals can be enticed or netted by the thought of monies from the public purse, they have had a hard time changing their attitudes and structure to accommodate these new “strings-attached” monies.

Public hostility toward these institutions is a major coercer of change within them. Nevertheless, a community power group must be careful not to swallow too much of its own rhetoric, not to believe too implicitly in its own limited experience. Money in the public purse is not simply money in the pocket of the community. Whole sets of regulations and audits limit and protect the use of these funds.

This paper may appear critical of the various parties involved in bringing about innovation in the way care is delivered in Baltimore. If, in the interest of being realistic, a pessimistic or harsh picture has been painted, so be it. The scene is one where great progress is being made. A new power structure may arise around the delivery of health care in the community. But, with the present political climate, it is doubtful whether it will be funded out of tax revenues. The influence of public opinion—from the community surrounding the hospital and from others—will continue to be a force for change. The community is trapped in its environment and the neighborhood hospital is in the net with it; they are mutually dependent on one another. Once this is more clearly understood by both parties, they may be able to create together rather than merely exist side by side. A new power structure may then arise around the delivery of local health services. Perhaps, somewhere along the way, if we are all lucky, a new spirit of cooperation based on mutual trust will also come forth.

REFERENCES


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