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New Partnership for Health? Business Groups on Health and Health Systems Agencies

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SYNOPSIS

The experience of the Central Massachusetts Health Systems Agency (CMHSA) and the Central Massachusetts Business Group on Health (CMBGH) demonstrates the feasibility of cooperation between HSAs and BGHs. Objectives and strategies of the two groups in carrying out community health planning and working for health systems change are compared.

Nearly two decades of government-sponsored community health planning programs, first through comprehensive health planning agencies and then through HSAs, have had less impact than many had anticipated because neither the technical nor political basis for such planning was sufficiently established. The CMHSA experience is typical, although it is credited with developing a hospital systems plan that is based on sound planning methods and statistical data. It is in the implementation of plans that the CMHSA has made slow progress, reflecting its inadequate community power base.

The CMBGH, 1 of more than 90 groups that have developed recently across the country to attack high health care costs, was formed in 1981 by business leaders to address these rising costs. The principal strategy adopted by the CMBGH involves fostering a competitive health care market by creating a critical number of competing health plans. The providers in each plan will then have incentives to provide effective care in an efficient manner to keep the premium competitive and attract enrollees.

Cooperation between the CMBGH and CMHSA is based on each organization's emphasizing its strengths. The CMHSA's data base and analyses have been the primary resources used by the CMBGH to identify problems. Each organization has developed its own set of goals and objectives, while keeping in mind those of the other organization. The CMBGH adopted a subset of the CMHSA's goals—those that focus on hospital capacity and utilization. Although the CMHSA's regulatory strategies differ greatly from the CMBGH's competition strategies, they do not necessarily conflict. Actually, each organization is supporting the other's strategies without deemphasizing its own. The CMBGH currently has a decisive advantage over the CMHSA in implementing activities because the business leaders are an integral part of the community power structure. Also, their companies' willingness to offer additional health plans to their employees is the prime incentive to develop such plans.

In 1966 the Comprehensive Health Planning and Public Health Service Amendments Act (Public Law 89–749), referred to as the Partnership for Health Act, called for consumers and providers of health care to join forces to plan improved health systems. In the more than 15 years of federally

sponsored community health planning that followed, including the National Health Planning and Resources Development Act of 1974 (Public Law 93–641), success in changing health systems has been limited at best. The impact of community health planning efforts has been less than anticipated because the United States was neither technically nor politically ready for this mandated partnership.

The data and methods that lead to an adequate understanding of how health systems operate have not been developed. The evaluations of health systems done by health planning agencies have reflected considerable staff effort, but they were not strong enough to bring about changes in the systems. Most often, analyses focused on one aspect of a health system, and they neglected interrelationships with other parts of the system. For example, when detailed service use studies were done, little or no attention was given to the interaction of utilization with costs or with effectiveness in terms of health status. The development of national and State guidelines and standards for health planning has been slow, and the process also has reflected narrow and inadequate analyses of health systems.

On the policymaking side, neither providers nor consumers have generally been ready to tackle the difficult decisionmaking that is necessary if more than superficial changes are to be made in today's health systems. In many instances, providers have been able to sell a status quo mentality to each other and to the consumers involved in health planning. Consumers were slow to learn the health system's ropes, and often they became subservient to providers' interests. Health planning agency staff frequently found themselves the only ones who proposed alternatives to the providers' points of view, and they had to fight with providers for consumer support.

Now I see signs of rebirth of the partnership for health concept. Leadership for this rebirth is coming from those paying the health care bill. Furthermore, I am optimistic that the United States may now be ready, both technically and politically, for this partnership. The partnership that I refer to is between the rapidly evolving business groups on health (BGHs) and the health systems agencies (HSAs). In this paper, I focus on local health planning, but I believe that my comments are also applicable to the State level—the State health planning and development agencies (SHPDAs) and statewide health coordinating councils.

A business group on health is a local organization, although a few are statewide, led by business executives whose primary purpose is to control health care costs. In early 1983, there were about 90 BGHs in the United States. Some restrict their membership to business representatives; others include hospital, physician, insurance company, and other health provider members. In most areas, these BGHs were founded because the members' companies' health insurance premium increases were unacceptably high. For instance, a 1982 survey by the Massachusetts Business Roundtable found 20 to 40 percent increases commonplace (*1*). Often BGH members expressed frustration with the largely unsuccessful attempts, usually by government or government-sponsored agencies, to control health care costs.

The current status of HSAs and SHPDAs indicates, that, in many areas, these agencies are likely to be around for some time although, clearly, Federal funding, especially of HSAs, is decreased substantially. The HSAs that continue to function are more likely to spend their scarce resources on project review (determination of need) activities than on developing health systems plans. Nevertheless, most HSAs have gone through several iterations of plan development, and their plans are well established.

In the new era of community health planning in the 1980s, it is crucial to take stock of past efforts. My purpose is to compare the objectives and strategies of health systems agencies and business groups on health and demonstrate a cooperative approach that builds upon the strengths of each organization. I shall use the experience of the Central Massachusetts Health Systems Agency (CMHSA) and the Central Massachusetts Business Group on Health (CMBGH) as an example. Their experience shows that cooperation to accomplish community health planning and policymaking is feasible, and further, that such joint endeavors may have far greater impact than past efforts. To begin, I shall describe the histories of the CMHSA and the CMBGH.

Central Massachusetts HSA

The CMHSA was designated in 1976 after making the transition from a regional comprehensive health planning "b" agency that was funded in the late 1960s. The area has a population of about 680,000; approximately one-half live in the center of the service area in Worcester and its suburbs. The greater Worcester area has been chronically overbedded, a factor related to the area's rank of third in hospital costs per capita and fifth in hospital utilization per capita among the 76 largest SMSAs nationwide in 1979.

The CMHSA released its first health systems plan late in 1977, and the staff has since prepared annual revisions of the plan. Each plan is more than 1,000 pages long and contains more than 100 goals and objectives that refer to a wide range of health services. An indepth examination reveals, however, that the plan's principal focus is on cost containment through reducing hospital capacity and on promoting alternatives to hospitalization.

It is important to recognize how the CMHSA analyzes the health system. Data and methods concentrate on resource (beds) availability and service use levels. The cost data employed are not adequate to identify specific problems, especially to facilitate interhospital comparisons. Diagnosis-specific data by hospital were not available until recently, and they have not been used in the HSA's plans.

Despite this limited ability to analyze hospital systems, the CMHSA employed normative use rates to identify excess hospital capacity in the three principal services: medical-surgical, obstetric, and pediatric services. Objectives of reducing this excess were translated into institution-specific recommendations for closures or mergers of hospitals, a step that only a few HSAs have taken.

This use-specific approach to hospital planning has had both positive and negative results (*2*). On the positive side, the CMHSA received an agreement in 1978 from Blue Cross of Massachusetts "to support and work closely with the CMHSA." The agreement continued: "This may very well include ceasing reimbursement to those hospitals which the HSA has determined to fail to meet the criteria of its plan . . ." The resultant closing of one small rural hospital and the phasing out of acute medical-surgical services in a Worcester hospital are related to these Blue Cross reimbursement sanctions. However, the impact of these actions on overbedding has been minimal. Furthermore, there has been no substantial progress on the CMHSA's recommendation to merge the municipal hospital and the university medical center in Worcester.

On the negative side, the tremendous controversy evoked by the plan's recommendations has taken a toll of board and staff time and aggravation. The CMHSA has held far more public hearings with far more people attending than most HSAs. The overwhelming majority of opinions expressed were against the plan in particular and the CMHSA in general. In the July 1978 elections of CMHSA board members, the municipal hospital in Worcester sponsored a slate of five candidates; all won seats handily since the 1,500 persons attending the election were largely bussed in by the hospital (*3*).

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The four annual revisions of the CMHSA's health plans since 1978 reflect attempts to maintain the original hospital-specific recommendations; recommendations to close units of other hospitals have been added. These plans do not represent substantial technical improvements, but rather further refinements of data and more details on the use of and availability of resources. Much of the added detail was generated by the appropriations review process.

From a policymaking perspective, the CMHSA staff and board fought difficult battles to keep intact the original plan's recommendations. Through project reviews, the CMHSA tackled a variety of issues ranging from abortion clinics to CT scanners, but this reactive process did not relate significantly to the hospital planning efforts, since hospital expansions were not proposed. There were, however, two exceptions. One CMHSA-approved project was the expansion of a hospital in the South County, where the plan identified a need for more beds. The other exception was a $25 million expansion of an outpatient department in a Worcester hospital. This project was withdrawn in 1981 after the CMHSA analysis produced negative recommendations.

The central difficulty in plan implementation is the CMHSA's lack of authority to put into effect its recommendations for shrinking hospital capacity. Blue Cross supported two hospital-specific recommendations, but it has not openly supported further actions. Although the CMHSA board members represented a variety of consumer and provider groups, few board members felt that they had a major stake in implementing the plan's proposals. The CMHSA staff attempted to provide the leadership to promote implementation, but they were successful only to the extent that they were able to marshal Blue Cross

support and also keep the issues before the public through media coverage and public meetings.

Central Massachusetts BGH

The Central Massachusetts Business Group on Health was formed and began meeting in early 1981, after almost 2 years of informal discussions of the need for the major private payors of health insurance premiums to get together and address common concerns. These informal discussions were led by two executives of Worcester's largest company who were the business representatives on the CMHSA board. The CMBGH membership consisted of 10 employers or employer organizations that included most of the largest employers in the area. By early 1983, membership had expanded to include 17 companies, 2 organizations representing large numbers of smaller businesses, and the Worcester municipal government.

The CMBGH spent its first 8 months getting acquainted both with the information available on the local health system and with the leaders of the hospital and physician community. Most of the work was done by the members themselves, who were, with a few exceptions, personnel or benefit managers of companies. A former CMHSA staff member gave the CMBGH staff assistance on a part-time basis. Three subcommittees of the group were formed with the following responsibilities:

- CMBGH-Medical Society Subcommittee meets monthly to discuss areas of interest both to the businessmen and to the physicians. Considerable attention has been given to ambulatory surgery programs and to overuse of hospital emergency rooms.
- Hospital Liaison Subcommittee has met with each hospital administrator to hear his concerns and ideas about progress.
- Prevention Subcommittee consists of occupational health physicians and nurses from CMBGH member companies. The group has produced working papers on specific programs, including cigarette smoking cessation programs and hypertension reduction programs.

By late 1981, the CMBGH had reached agreement among its members that the high health care costs in central Massachusetts were related to excess supply and overuse of hospitals. The group identified the principal cause of these excesses as the existing incentives that result from third-party insurance plans that hide from the individual consumer the high costs of health care. Another important cause is the provider reimbursement mechanisms that reward providers for producing more, and more costly, services.

In early 1982, the CMBGH adopted objectives that seek to constrain the increase in health care costs while maintaining appropriate use and quality levels. The principal strategy for accomplishing this objective is to foster the establishment of a series of competitive health plans. These competitive plans are defined as health care financing and delivery programs that provide incentives to deliver high quality, personal health services at an affordable price. Criteria for such programs are prepaid fixed premiums; provision of services by an identified set of physicians, hospitals, and other health care providers; and assumption or sharing of financial risk by member providers. Competitive health plans are viewed as including, but not limited to, preferred provider organizations, closed-panel HMOs, hospital-based HMOs, independent practice association HMOs, network HMOs, and hospital capitation projects.

The CMBGH has developed liaisons with specific hospitals, health insurance companies, and other provider groups that are interested in developing competitive health plans. To formalize this liaison and convert it into action, the CMBGH formed Worcester Area Systems for Affordable Health Care (WASAHC) in August 1982. WASAHC's governing body consists of four CMBGH members, four health provider groups (hospitals and insurance companies) that are developing competitive health plans, and representatives of the labor and physician community. WASAHC's board chairman is a recently retired senior vice president of a $1.3 billion multinational corporation with corporate headquarters in Worcester.

In addition, the CMBGH devotes considerable effort to educating key organizations and persons about the existing problems of health care and the objectives and strategies of the group. Its target groups include hospital trustees, company presidents, and other business leaders. The CMBGH is coordinating its efforts, especially in education and legislation, with the Health Care Task Force of the Massachusetts Business Roundtable, a statewide group. This statewide group in May 1982 released three reports designed to inform business leaders of the problems of health care costs: "Health Care Costs in Massachusetts" (*4*), "Health Care Benefits Survey—Attitudes and Financial Experiences of MBR Member Firms" (*1*), and "Toward Competition in Boston's Health Care Market" (*5*). Upcoming roundtable programs to educate hospital trustees will be based on these documents.

A Cooperative Approach

Having described the CMHSA and CMBGH, let me examine the Central Massachusetts experience that demonstrates the complementary strengths of these two organizations. This cooperation increases dramatically the chance of achieving results. The CMHSA and CMBGH have a common purpose—to make health systems function in a more efficient and effective manner. Although many business groups on health seem to be somewhat myopically concerned with reducing employee health insurance premium payments, the CMBGH recognized early that the only true solutions to the health care cost problem will come from communitywide changes.

The strategies of the CMHSA and CMBGH vary, especially in their relative emphasis on regulatory versus competitive approaches. There is a potential for major conflict over these approaches, and this threat may explain what seems to be a fairly widespread hostility between BGHs and existing government or government-sponsored agencies like HSAs and SHPDAs. In central Massachusetts this conflict has been avoided because the organizations coordinate planning and policymaking activities so that each organization gives way to the other in certain activities according to each organization's strengths —both technical and political. This tactic is the key to successful cooperation.

I find it useful in examining health planning practice to distinguish the various planning steps: health system analysis, goals and objectives setting, strategy or program development, and implementation (*6*). It should be clear from the descriptions earlier in this paper that the CMHSA devoted large amounts of time and resources to the early planning steps—analyzing the health system and specifying desired changes. As the CMHSA's success in achieving results has grown more and more limited, the CMBGH, representing a potentially strong political constituency, came on the scene. The CMBGH introduced some new strategies, but it also supported some of the CMHSA's strategies. The dynamics and interplay are best viewed by looking at each planning step, as is done in the remainder of this section. This perspective also serves to communicate some guidelines for other communities.

The primary source for evaluating the performance of the health system has been the CMHSA's data base and analyses. Most of this information is published in the health system plans, although additional data are in easily accessible reports. From this base, the CMBGH developed a clear picture of the problems that existed, especially in the hospital sector, which was the group's primary focus since hospitals comprise the largest piece of the health care cost pie. While improved data, particularly on costs and effectiveness, were needed, the overuse and overbedding in the Worcester area were so apparent that plans for action did not have to be delayed.

It is noteworthy that the CMBGH member companies are moving to acquire more specific and meaningful data on individual hospitals. Many companies have obtained from their insurors detailed data on cost and utilization of health services by their employees, including the types and quantities of services consumed, specific costs, place of delivery, and diagnosis or diagnosis-related group. Still to come, but potentially available, is considerable information on employees' health. Companies know when employees die and when they are sick, disabled, or absent, and, perhaps, even when they are dissatisfied—all indicators of health or well-being. This information might be used to study the health system's effectiveness through linkage to information on service use or nonuse.

The CMHSA and CMBGH have developed their own goals and objectives, but each has also kept in mind those of the other organization. As described earlier, the CMHSA has completed five annual planning cycles to develop and refine plans that contained hundreds of goals and objectives. The CMBGH had all of this material to use in its deliberations, and essentially the group adopted a subset of the CMHSA's goals—those that focused on hospital capacity and utilization.

In developing specific strategies and programs, some divergencies of focus between the CMHSA and CMBGH become apparent. The CMHSA, and I believe most HSAs, has tried to attack hospital overbedding and overuse directly by regulating hospital growth through determination of need programs and by stimulating public outcry for reductions in the number of beds. The CMBGH adopted strategies that are more indirect, but they focus on the underlying problem—the lack of incentives that reward providers for performing efficiently. The CMBGH strategy is to create a critical number of health plans. As the decisionmakers within each health plan act to supply needed services to their enrollees while holding down costs, the overall effect should be to control costs. A related effect should be to drive out inefficient providers, especially inefficient hospitals, thereby shrinking the system's capacity and decreasing the supply-induced pressure to hospitalize.

The CMHSA supports the CMBGH's competitive strategy. Actually, in its planning documents the

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CMHSA has supported local development of HMOs and called for HMO expansions. The CMBGH strategy represented more a difference in emphasis than a disagreement with CMHSA's policies. However, the CMHSA cautioned the CMBGH that excess hospital capacity in the Worcester area was so great that the group's competition strategy should be complemented by a regulatory strategy that included a determination of needs program as well as efforts to close hospitals and hospital service units. The CMBGH agreed, and it has supported the CMHSA's determination of need activities, primarily through the two CMBGH representatives who serve on the CMHSA Board of Directors. Furthermore, the agenda of WASAHC, the CMBGH's implementation arm, was expanded in late 1982 to encompass efforts to shrink the hospital system in addition to its mandate to promote other competitive health plans.

It is in implementation activities that the CMBGH currently has a decisive advantage over the CMHSA, particularly because the existing political environment is not strongly supportive of governmental regulation. This advantage is twofold. First, CMBGH members represent large companies that have the capability, either directly or through third-party insurors, to make major changes in the incentives that direct the behavior of both health providers and consumers. The CMBGH's power stems from the willingness of its member companies to add new health care plans to the choices that they make available to employees. This potential market gives an incentive to those hospitals, insurance companies, or other health providers interested in developing such plans.

In response to CMBGH's call for competitive health plans, three Worcester hospitals and an insurance company decided in August 1982 to begin developing their own health plans. These four plans, plus the existing closed-panel HMO and IPA HMO, should provide the competitive forces promoted by the CMBGH.

Second, many executives of CMBGH member companies are an integral part of the community power structure, and they can therefore become key proponents of health system changes. Most often, they prefer to work behind the scenes and person to person, employing different tactics than the CMHSA's public meeting and newspaper publicity approach. Also, the CMBGH has considerable clout because many trustees of local hospitals are businessmen. If the CMBGH can persuade these business leaders that changes are necessary, the chances for implementation are increased.

It seems to me that the CMHSA-CMBGH relationship not only is conducive to achieving dramatic results employing the competition strategy, but also provides flexibility. If the CMBGH, in parallel with its competition strategy or in the future, chooses to try to control health care costs through regulation, these business leaders can provide the impetus to implementation that the CMHSA has lacked. This happened, for example, when business leaders throughout Massachusetts linked up with State government officials and others and in 1982 passed the State's hospital prospective payment law (7).

Guidelines for BGH-HSA Cooperation

Based on the Central Massachusetts experience, I offer the following guidance for effective BGH-HSA cooperation. Start by comparing broad goals and objectives. Almost all HSAs have proffered the goals of seeking to control costs while maintaining high quality health care, accessible to all groups, but the BGH may have the narrower focus of simply controlling costs. The HSA should use the information generated by its analyses to demonstrate the interdependence of cost, quality or effectiveness, and access. The attempt to get the BGH to adopt a broader systems approach should include efforts to convince its members that controlling business's health costs means controlling the community's health costs. Anything less probably will simply shift costs from one group (business) to another (Medicare, Medicaid).

Although the BGH can generate information that permits improved analysis of health systems' performance, the HSA's data base and completed analyses are most likely sufficient starting points for action. The BGH should not get bogged down in the time or expense of massive data collection and analysis efforts.

The debate over regulation versus competition as strategy is counter-productive because both are important. The political climate merely dictates the relative emphasis. What is crucial is whether community forces can be marshaled to implement either or both strategies effectively. If the BGH is espousing competition in the form discussed in this paper, then it behooves the HSA to offer all the support it can muster. At the same time, BGH members should assist the HSA in its regulatory efforts, and they should not delude themselves into thinking that the forces of competition will rapidly replace the need for regulation. I have not heard any advocate of competition who knows the health care field well argue that such a short time frame is realistic.

Finally, both HSAs and BGHs should focus on results. Business leaders are result-oriented people, and thus they are quick to move from planning to implementing. HSAs are well advised to observe the BGH's implementation activities carefully. How desired changes are implemented in the community is the lesson that far too few HSAs have learned. If the BGH and HSA forge ahead with a cooperative spirit, I think that we may see throughout the United States the joining of health consumers and providers into the kind of partnership for community health planning and action that has been envisioned for nearly two decades.

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LETTER TO THE EDITOR

Ophthalmia Neonatorum Prophylaxis

The article "Ophthalmia Neonatorum Prophylaxis in Vermont," by Richard L. Vogt et al., which appeared in the March–April 1983 issue of *Public Health Reports,* is of great interest to me for two reasons: during the period 1952–57 I was the Vermont State Epidemiologist, and during the period 1973–81 I was the Director of Public Health in New Hampshire. Therefore, the article struck a responsive chord in my memory.

First of all, I wish to commend Dr. Vogt and his coworkers for the excellent study and the benefits derived therefrom. I'm sure that the responsible hospital personnel only needed to be reminded of the proper prophylactic medications, and were quick to cooperate.

Home deliveries are certainly another matter, especially when the attendant is a lay midwife. Dr. Vogt might have mentioned in his article some of the social reasons why there was noncompliance in the home situation. We observed in New Hampshire a strong resistance to the use of drops in the newborn's eyes among those young parents who wanted everything to be "natural" and strenuously objected to medication of any type. This was especially true in the setting of the "commune," where otherwise intelligent, reasonably well-educated people tried to live apart from the rest of society. Often they would choose one of their number (not necessarily blessed with any kind of medical or nursing education) to act as "midwife" when the occasion arose. The omission of prophylactic drops was therefore willful.

Another argument I used to hear was the implied insult to the young mother, in that the use of drops in the infant suggested that mother might have a venereal disease, and this thought was just too revolting to be considered!

As for the possible interference with bonding, that problem has been solved by the slightly delayed instillation of drops (after mother and child have had a chance to achieve eye contact).

The preceding comments are certainly not intended in any way as criticism, but only to point out the need for attention to the precepts of cultural anthropology.

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