

Health Care Coalitions:  
New Substance  
Or More Cosmetics

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## THE SPEAKER

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## THE OCCASION

Prof. McNerney delivered this lecture at the University of Chicago on May 20, 1982.

## *Health Care Coalitions: New Substance or More Cosmetics?*

In one form or another, community health institutions have planned together voluntarily for many years; health care coalitions are the newest brand name. What are these coalitions like? Do they have value and reasonable permanence? Are they another transient scheme, or worse, an easy way out while tougher public policy decisions are ignored?

While similar to predecessor affiliations in some ways, coalitions have unique aspects which vary with their locations. For example, they are much more concerned with cost containment than with access, continuity of care, or regionalization (yesterday's buzz words); they are more often inspired by buyers of health services than by representatives of health institutions; and, although local in nature, they are nationally espoused.

## WHAT ARE THEY LIKE?

By now, the characteristics of coalitions are fairly well known and reported. Only a few salient features need be mentioned here:

1. As of April 1982, the total number of coalitions reported was over ninety.
2. Coalitions are located in thirty-one states and in all regions of the country. The majority are in urban areas. Thirteen are statewide, as, for example, in Utah and Minnesota.
3. The majority of coalitions are sponsored by business firms. Second in frequency are those sponsored by the American Medical Association, followed in significantly fewer numbers by those sponsored by insurance companies, Blue Cross and Blue Shield Plans, and Health Service Agencies (HSAs). In two states, Florida and Oklahoma, the governor was deeply involved as a sponsor.
4. Coalitions' agendas vary. The major items include utilization review, development of a

fact base, support of area-wide planning, health promotion, benefits modification, support and development of alternative delivery systems, and encouragement of corporate trustees to assume active roles. One-half of the coalitions report four or more agenda items.

5. In regard to membership, as opposed to sponsorship, some coalitions are composed entirely of business representatives and others include, variously, doctor, hospital, carrier, labor, and government representatives. The level of representation varies widely (particularly among business coalitions), from, for example, benefit managers to chief executive officers (CEOs).

6. Annual budgets reported vary from zero to \$236,000. Assessments appear to be in the \$1,000–\$5,000 range.

7. The majority of coalitions are incorporated as nonprofit agencies or are unincorporated. None is a government institution.

8. The number of coalitions is growing rapidly.

Although the coalitions that are known have “permanent” addresses, descriptive data are weak and several simply do not answer the phone. Clearly, health care coalitions are in an early formative stage, seeking an identity in a variety of forms and places.

## ROOTS

Some coalitions have been independent local creations, as, for example, in Cleveland, Philadelphia, and San Diego. The majority have been stimulated by such groups as the Business Roundtable Task Force on Health, the Washington Business Group on Health, the Chamber of Commerce Health Action Program, the American Medical Association (stemming from the Commission on the Costs of Medical Care and State Counterparts, plus the Corporate Visitation Program started in 1978), the growth of business involvement over the years in

HSAs, the Voluntary Effort, and, most recently, the Dunlop Committee.<sup>1</sup>

Buyer representatives are unmistakably motivated by a desire to contain health care costs through mutual effort. Provider representatives appear to prefer local, voluntary effort in almost any form to recent regulation and legislative edicts from the federal and state governments, and, in any event, they want a seat at the table when cost containment is discussed.

## RESULTS

Because little data are available, it is difficult to evaluate the results of coalitions at this point, just as it is difficult to describe the coalition movement accurately. It appears as though most of the action so far involves sharing experiences and a quest for reliable information on utilization and costs.

A few claims have been made, for example, that utilization review, health promotion programs, and Health Maintenance Organization (HMO) endorsements are saving employers money; it has also been alleged that the Michigan Health Economic Coalition is reducing the number of hospital beds in Michigan. However, these claims have not been assessed. The majority of coalitions claim very little. They evoke favorable images, they seem to fit nicely the flow of political events, but outcome measures lie ahead.

## WHAT ARE THE PROSPECTS?

The prospects for coalitions are not clear. Opinions run the gamut from disdain to enthusiastic endorsement. Lacking information, each observer feels especially secure in his or her position.

<sup>1</sup>A group constituted in mid-1981 and focused specifically on local coalitions and coordinated by John T. Dunlop, professor of economics, Harvard University. Participants include: American Hospital Association, American Medical Association, Blue Cross/Blue Shield, Health Insurance Association of America, Business Roundtable, and AFL/CIO.

At this juncture, all one can do is speculate about the prospects after considering the forces that seem to be supporting coalitions and those that are retarding or opposing their creation or growth.

#### FORCES IN SUPPORT

1. Health care costs are of deep and growing concern. In 1981, several major carriers experienced significant deficits. Projections for 1982 are not encouraging. The federal government has also realized major, unanticipated health expenses and is acting to end its open-ended commitment to the aged and low-income groups. Most state governments have neither the funds nor the administrative expertise to pick up much of the slack. Furthermore, employers, equally concerned about rising costs, are acting aggressively to limit their involvement. Thus a process of cost shifting has begun that will ultimately center on individuals and community institutions at the local level. In a sluggish economy, neither is well equipped to withstand the burden. Legislative proposals in the Congress offer little relief. As a result, cost-containment pressures from both the public and private sectors will likely increase. Coalitions emerge, potentially, as mechanisms to focus community effort on areas where cost shifting hurts the most, provide for some relief in the absence of alternative solutions, and harness a growing amount of grass-roots creativity.

2. In communities across the nation, we see many new types of activism. The health field is not alone in its initiatives. As pointed out by John Herbers in the *New York Times*, local and regional coalitions have formed around economic and even international issues, such as water rights, proper use of block grants, and nuclear war.<sup>2</sup> Most are "less confrontational"

<sup>2</sup>John Herbers, "Citizens' Activism Gaining in Nation: Coalitions Forming on Issues from Arms to Economics," *New York Times* (May 16, 1982), pp. 1, 12.

than those formed in the 1960s and involve an older age mix. Clearly, people seem to be "disillusioned with the prospects of influencing the national government" and feel that greater leverage is possible at local levels. The *permanence* of the shift is hard to determine, but the shift, Herbers says, is in keeping with the American tradition of policies bubbling up from the local community and a perception that these policies are more effective in the long run. Protests organized by national organizations in the 1960s and 1970s were the aberrations, as were intensive, top-down government interventions. The forces bearing on health coalitions have a larger context that is neither illusory nor very transient.

3. The application of new market forces is proceeding slowly, and people are tired of excessive, detailed regulation. Specifically, trustees, doctors, hospital administrators, and intermediary and carrier representatives are frustrated with perceived excesses in government regulation. In addition, serious questions have been raised about how applicable regulation is to the health field in the long run. Alfred E. Kahn points out that the health field is extraordinarily complex, "with wide variations of circumstances from one locality to another"; there are, "inevitably, distortions and arbitrations involved in any prescriptive regulatory scheme." In the health field there is special difficulty in "defining a unit of service," thus ease in evading regulation; and, given the importance and subjectivity of human services, heavy political pressures are usually involved, for example, against closing beds.<sup>3</sup> The question might be asked, if the market is only a partial remedy at this time, and regulation has palpable limits, do we have any alternative but

<sup>3</sup>Alfred E. Kahn, "Health Care Economics: Paths to Structural Reform," in *A New Approach to the Economics of Health Care*, ed. Mancur Olson (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1980).

to form coalitions, or something like them, among other voluntary initiatives?

4. Employers, major instigators of coalitions, will probably pay a good share of the private health bill for those under age sixty-five in the 1980s. Their interest in community solutions is likely to be sustained. Although some are tempted to go it alone and work directly with individual hospitals on preferred payment bases, most realize that in many communities, none has sufficient leverage and all are needed, acting in concert, to effect change.

5. Coalitions are widely supported, which is understandable. Far more than employers are on the line. As pointed out, employers, labor representatives, and carriers clearly will seize opportunities to get a better grip on costs. Hospitals, doctors, medical centers, and others want to be involved to avoid arbitrary decisions and to lend what they perceive to be special knowledge and expertise.

6. The President's Task Force on Private Initiatives and others are now actively supporting private initiatives as a positive force.<sup>4</sup> The task force sees the country in the midst of a re-evaluation of how problems are to be defined and solved. The members see people taking "the future into their own hands in their own communities," addressing needs through a "working partnership of both public and private sectors" rather than choosing one over the other. They use extravagant language, for example, "America's rich traditions began with simple acts of neighbor caring for neighbor." They point to the fact that 84 million Americans did volunteer work between March 1980 and March 1981, 91 percent of whom also made charitable contributions (health was second only to religion in the amount of contributed time). Coalitions fit this formulation.

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<sup>4</sup>The President's Task Force on Private Sector Initiatives, "The Role of the Private Sector in Partnerships" (undated and unsigned statement obtained from William D. Verity, chairman).

7. Coalitions are not abusive. By definition, they are conciliatory. Their very flexibility makes them sensitive to, or at least adaptive to, the complexities of human service.

8. The health field still lacks reliable outcome measures. As a result, negotiation and compromise are essential, and coalitions can provide a suitable framework for both.

Given all of the above, the way is not smooth. Other forces are arrayed against coalitions. Some examples follow.

#### FORCES AGAINST

1. There is some feeling that we have tried this before and it has not worked; consider, for instance, what happened to voluntary planning at the local level. We had to replace most of it with HSAs, and they have not worked very well either. However, there were some distinguished examples of voluntary planning,<sup>5</sup> and the tour de force legislation of the 1960s and 1970s certainly fell short of the mark. Through this lens, coalitions are viewed with some ambivalence.

2. Mutual effort under the Planning Act (PL 93-641) per se did not work well, and it is clear that the Reagan administration, skeptical of its impact on costs and suspicious that it restricts rather than enhances entry to the health market, intends to repeal most of its provisions. Are coalitions sufficiently different from the Planning Act?

3. It has been pointed out that after modest successes, the Voluntary Effort was not effective. The numerical objectives were handicapped by an unanticipated inflation rate; there was only an uneasy consensus about the causes of rising health care costs, and, although national health associations tried hard, the local levels never got enthusiastically involved.

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<sup>5</sup>For example, Hospital Planning Association of Allegheny County, Pa., in the 1960s, and similar associations in Rochester, N.Y., and Detroit, Mich.

4. In the deregulating health market of the 1980s, several providers and health professionals are thinking less in community and more in institutional terms. One hears more about, "How does my institution come out?" and less about "Neighbor helping neighbor." Hospital representatives in some areas are suspicious and apprehensive about coalitions. They see benefit managers from industry trying to squeeze providers—e.g., through Preferred Provider Organizations (PPOs) and Blue Cross Plans—and suspect that coalitions will be used toward the same end. Business representatives are apt to be viewed by provider representatives as not very knowledgeable about health and more in the mold of a surveillance group. The data bases are often seen as duplicative or meaningless. Similarly, local physicians are apt to be wary. In Des Moines, providers, doctors, and businessmen split over an HMO project, and the businessmen formed a new association to develop an HMO.<sup>6</sup> Whether the inherent suspicions can be overcome is a key question.

5. From a different vantage point, many employers see providers as an ingrained part of the cost problem. Often, despite cost-containment programs, Blue Cross and Blue Shield Plans and other carriers are also viewed as less aggressively interested in cost containment than the buyer would wish. Thus, a we/they attitude is apt to develop within the somewhat narrow perspective of a fringe benefit. It should have come as no surprise that when the Dunlop Committee issued its statement calling for *community* coalitions and for *all* major parties to be represented,<sup>7</sup> many business representatives (many of whom were benefit managers) wrote John Dunlop rather stiff letters protesting the presence of other than buyers at the table,

<sup>6</sup>John K. Iglehart, "Health Policy Report," *New England Journal of Medicine* (January 14, 1982), pp. 120–24.

<sup>7</sup>Dunlop Committee, *Coalitions for Health Care* (January 14, 1982).

almost as if an adversary relationship were preferred.

Professor Sapolsky of MIT recently reported<sup>8</sup> that a survey of CEOs revealed less than total concern about health care costs, at odds with growing evidence to the contrary.<sup>9</sup> Whatever their predilections, few CEOs are directly involved in coalition activities; other officers generally are active. The absence of the CEO is apt to narrow the perspective of the issues, giving them a more technical than community flavor.

Again, the question is raised: In addressing what are essentially community problems, can the adversarial attitudes of employer representatives be overcome?

6. Labor representatives have only recently joined the coalition movement at the national level, primarily through the Dunlop Committee. From the beginning they have been involved in selected localities, reflecting local traditions. At the national level, labor has made it clear that support of coalitions does not signify a diminished interest in comprehensive national health insurance, in regulation, or in the work environment; rather, the national support seems to reflect a temporarily acceptable alternative and a desire to be involved rather than be left on the sidelines. With diminished ranks and less political influence, it appears as though labor's traditional objectives, largely consumer oriented, will be pursued mainly at the local level and thus will vary significantly.

7. Legal restrictions are often cited as im-

<sup>8</sup>H. M. Sapolsky, D. Altman, R. Greene, and J. D. Moore, "Corporate Attitudes toward Health Care Costs," *Milbank Memorial Fund Quarterly* 59 (1981): 561–85.

<sup>9</sup>For example, Business Roundtable, Chamber of Commerce, and other associations have designated health costs as a major priority on their action agendas; selected firms are educating officers, including CEOs, in health issues. In fact, CEOs are much more conversant in 1982 than they were in 1975 about fringe-benefit costs (now approaching 40 percent of payroll), including health benefit costs (rapidly becoming the largest element).

pediments to the growth of coalitions. Indeed they could be, if purposes or methods are unwisely selected. Joint activity, no matter how nobly stated, cannot manipulate prices or cause boycotts. However, it appears likely that most coalitions will be more guilty of passivity than of aggression, and where contentions arise the rule of reason will be applied, balancing many factors. For example, sharing data will not be perceived automatically as bad; rather, the net result of their use will be examined. In any event, most challenges are less likely to come from the federal government than from aggrieved hospitals or doctors. Overall, legal restrictions appear to be containable, except as they conveniently protect someone's territory.

8. Finally, the initial focus of many coalitions is not all that encouraging. The Dunlop statement speaks of access for the unemployed and others, health promotion, and disease prevention at the place of work, but its overriding objective is clearly cost containment focused on the hospital and doctor. Most coalitions have the same objective, at the expense of a community-wide appraisal, better management of health institutions, continuity of care geared to proper sites, and environmental and lifestyle programs. The early efforts, at least, appear to be centered on the old rhythms of utilization review instead of such gut issues as changing the delivery system. Granted, it is difficult for fledgling institutions to take on complex issues, especially with minimal funding, but much of the action to date seems to have a kiss-and-run aspect to it and to ignore the fact that the essential worth of a coalition is not gauged by its funding but by the commitment of community leadership.

Given the fact that there are forces in support of coalitions and others arrayed against or at least impeding them, what is the bottom line?

It is not fair to put coalitions in the same camp as either the Voluntary Effort or area-wide planning and then write them off as stereotypes. The design of coalitions is

significantly different from the others to be judged on its own merits. In fact, several features seem to overcome the perceived weaknesses in the Voluntary Effort and planning. Attitudes can be changed with leadership. Legal obstacles do not appear great. Alternatives are few. It comes down to whether coalitions will be made to work, not whether they are feasible in a technical sense. In fact, there may be more going for them than against them. In a long-term perspective, coalitions run with the grain of our traditions, and in the short term there is growing mutual interest in at least one unifying target—costs. There is reason to believe that the weak start in many areas can be overcome. Now is the critical period as the Business Roundtable, Chamber of Commerce, providers, and others jockey for position and as the new Robert Wood Johnson project, under Robert Sigmond's leadership, sets out to provide examples of the proper course.

#### PRACTICAL EXPERIENCE FROM OTHER FIELDS

If strong coalitions are at least conceptually feasible, what are the key operational hurdles to be overcome? Can we find some clues from other similar experiences relevant to this critically important question? Stanley J. Brody and others have promulgated a few highly useful guidelines that could make the difference between success and failure.<sup>10</sup> These guidelines include the following:

1. It is important to accept the fact that the health field is highly complex, and thus, to many of the issues posed, there are no easy answers.

2. In forming coalitions of any kind, all or most key representatives with vested interests

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<sup>10</sup>Stanley J. Brody, "The Coalition and the Voluntary Effort" (informal paper, Social Planning Department of Physical Medicine and Rehabilitation, University of Pennsylvania).

must be involved, and each should be clear about his or her goals and convinced that joining is relevant. Key parties left on the outside can severely retard or stop the coalition's progress.

3. There must be mutual respect among participants and reasonable commonality of purpose.

4. People at the table should have authority to make commitments.

5. Strategies discussed must have credibility in the light of previous events.

6. Using the need to attack stereotypical "evils," such as hospital costs, as motivating forces should be avoided in favor of more positive ideas.

7. A spirit of negotiation and compromise should prevail by which everyone makes trade-offs and everyone wins. However, it must be recognized that some individual goals cannot be subordinated to the group.

8. Specific goals tend to lead to longer-lived commitments, whereas broader goals, with broader support, tend to have shorter life spans. In any event, the key is effectiveness in the light of all known conditions.

Presented thus, without the context of a specific environment, the guidelines seem somewhat abstract, but clearly they have relevance and application.

As one reflects on the guidelines, a central truth emerges, namely, that for a coalition to succeed, a sense of community must prevail, despite differences. Can this sense be captured in communities around the country and can we live with guidelines? These considerations, along with supportive and opposing forces, deserve examination. Again, the path is not easy to follow.

There are reasons to be cautiously optimistic. Certainly there are divergent interests among the many parties concerned with health. However, there is also a long-standing community interest and concern across the country about the importance of health services for all per-

sons, not just the privileged, and a strong individual impulse to have effective care available when it is needed (which is often unpredictable). The issue is not one-sided.

Hospital administrators and the increasing number of doctors who are now part of institutional arrangements should not be strangers to negotiation and compromise. In fact, it could be argued that these features are the essence of health institutional management. In a sense, hospitals are coalitions, as were Blue Cross and Blue Shield Plans at one time. Furthermore, negotiation and compromise should not be new to business representatives. Behind the business corporation's facade of order and command lies a lot of give and take. Certainly collective bargaining has provided both labor and management with relevant experience. Although individual doctors and consumers without a constituency can be difficult partners, they are, increasingly, in the minority.

In short, mutual respect among diverse interests is reasonably strong. It is not ideal, but it appears strong enough to respond to nourishment.

With reference to the guidelines, there are also problems to be addressed.

Given the fact that hospitals are, to some extent, coalitions, is there enough consensus among board, administration, and medical staff members regarding mission, goals, and major strategies for any of the participants to make commitments with reasonable authority? In many instances to date, commitments have not been possible. Differences have been all too real, and the problems have been compounded when two or more hospitals were represented. If interacting coalitions and hospitals were to sharpen leadership in each by responding to the needs of the other, coalitions would "pay their dues" on the strength of this contribution alone.

Can a few CEOs, or other lower-ranked business representatives, speak for other lines of business or for competitors? Is ability to com-



mit reserved only for those few, but notable, communities with one or two or three dominant industries? Thus far, commitment has been relative, as it has been with labor representatives and among physicians.

In examining the balance of cohesive and fragmenting forces, a central question becomes: how much substance should the coalition address? This question leads to another puzzle.

If our cost problems are intolerable and regulation is not working, if we believe in local efforts and initiatives, must not the coalitions, if they are to make the difference, address the problem of changing the delivery and financing systems, separately and, increasingly, in concert? Data gathering, health promotion, education of trustees, and utilization review are useful but fall far short of institutional reforms. Selective cost sharing can be defended, but excessive reliance on the individual to pay for premiums or care amounts to a negation of responsibility. Also, as the recent *Ford* settlement revealed, labor can be adamant on this issue. PPO arrangements negotiated by individual companies can fortuitously constitute a community contribution, but they can also exacerbate segmentation of the insurance pool. (A collective PPO is, of course, an organization called *Blue Cross*.)

A substantive involvement would necessitate, among other strategies, a community-wide address to capital expenditures, new incentive financing schemes, promotion of new delivery/financing systems, and deliberations about the growing problems of the aged—requiring, perhaps, a new definition of “health.”

The dilemma is apparent. To be effective, the coalition must make a difference. However, if it bites off too much, support may be lacking. Can the conservative notion of local effort accept the liberal challenge of leadership?

In this context, it is interesting to see doctors tempted by the need for leadership (e.g., the recent AMA Commission on Costs of Medical

Care) yet, locally, in several areas, fighting HMOs and alternates to “usual-customary-reasonable” (UCR) payments. The Dunlop Committee notwithstanding, there is active disagreement about the use of cost-sharing techniques, national health insurance, and the balance of incentive versus regulation. Furthermore, we see strange and unstable partnerships—for example, that between labor and commercial insurance companies in support of prospective budgeting systems and rate setting.

Overall, the evidence seems to favor the proposition that, operationally, negotiation and compromise can work, there is enough glue. After all, the Dunlop Committee does exist and so do local coalitions. However, if the guidelines are to be met, if issues are to be addressed successfully, coalitions cannot move too fast.

In essence, to succeed, coalitions must resist the temptation to swing at every pitch, to solve all problems now because someone deems them “urgent”; rather, they must build trust and programs with a sense of pace. Coalitions must not see themselves as the only change agents in the community, even over the long haul. Furthermore, they must accept the essential challenge of exciting others to action, that is, working through others. Becoming correctly established in terms of mission, content, and timing is of fundamental importance and needs to be debated in each community. To date, too many expedient and excessively imitative steps have been taken at local levels, as if coalitions had a meaning apart from the widely varying characters of communities.

In February 1982, the Robert Wood Johnson Foundation announced a \$16.2 million grant program entitled Community Programs for Affordable Health Care, under the direction of Robert Sigmond and cosponsored by the American Hospital Association and the Blue Cross and Blue Shield Association. This program has great potential for helping clarify the

many issues involved. The purpose of the program is to demonstrate the ability of various community representatives (hospitals, Blue Cross and Blue Shield Plans, other carriers, business, labor, physicians, and others) to work together to carry out significant local health care strategies involving necessary restructuring of the ways health services are provided or paid for. Cost containment is a prime target, but applicants are asked also to address the problems of providing care to the community's low-income populations. The recently distributed program description gives every evidence of a high degree of sensitivity not only to objectives but also to the importance of broad community involvement and commitment.

#### ARE COALITIONS SUBSTITUTES FOR AREA-WIDE PLANNING?

This nagging question is often asked. The discussion above goes a long way toward answering the question, but a few additional comments may be helpful.

Currently, the vast majority of coalitions are too frail to undertake all aspects of planning, even if it made sense to do so. Some of the inherent dynamics of planning would break up the average coalition. Beyond this basic point, there are other considerations. Coalitions do not, as a practical matter, cover all geographical areas or all institutions. Some health strategies should be addressed on a multicomunity basis; natural markets often involve more than one community. In planning five to ten years ahead, individual institutions need a regional and state environmental analysis to anticipate often significant changes. Buyers and carriers also need broad reference points. Furthermore, at the state level, separate from the planning process per se but often seen as an integral part of planning legislation, there must be a regulatory authority serving as a "court of last resort" to address issues that cannot be compromised within or among communities and, at times, to

provide sufficient speed of decision making to overcome the sometimes glacial aspects of compromise.

Thus we need to change PL 93-641, not scuttle it. The last four or five years have taught us some lessons. For example, in revising the law, we should settle for fewer, more precisely defined goals; involve less top-down, detailed regulation; provide greater flexibility to the states and local areas; actively encourage institutional planning and local initiatives; keep planning and regulation in separate contexts; and provide modest funds to help states, while encouraging private funds, especially from users, at the local level.

Given this formulation, coalitions can be essential *partners* by helping to promote consensus within communities, assisting with implementation strategies, handling unanticipated ad hoc situations, and, in general, facilitating communication.

Recently, certain members of Congress calling for the termination of federal planning legislation cited coalitions as the ready substitute. This type of burden could sink coalitions. It is conceivable that with the termination of PL 93-641, some coalitions will want to take on local planning functions, but if they do, clearly they must accept the responsibilities that go along with them, including much more aggressive interest in access to care and wellness in addition to cost containment. Also, they will cease to be coalitions as we have defined coalitions to date, that is, as essentially a facilitative force.

In any event, if coalitions are to work, business representatives and others should aggressively support planning and not straddle the issue. Some have been supportive. For example, in Cleveland the coalition is thinking of funding HSAs. In Rochester, New York, the coalition is studying ways of keeping the HSA, or its equivalent, afloat after September 1982. Planning presents employers with a difficult legislative choice. On the one hand, they stand

traditionally for deregulation—that is, when their own industry is not involved (which in 1982 puts them in pleasant alignment with the president). On the other hand, as managers, they are extremely wary of capital costs in the health field without some form of discipline. Publicly, employers support the president through the Business Roundtable and other instruments. Privately, they send representatives to the Hill to support a continuation of planning. Planning and coalitions need to be brought into clearer focus. Although they have the potential to be mutually reinforcing, viewed inappropriately as totally interchangeable parts in all communities, they can be mutually destructive.

#### THE FUTURE

In looking ahead, one can predict that neither regulation nor competition, alone or in combination, can provide satisfactory answers to health cost, access, or quality problems. Regulation has been put to the test and has been found to have limitations. Competition in fuller flower will take ten to fifteen years to evaluate. Voluntarism as a third force will be needed, especially now, to pick up slack; but most important, even fifteen years from now, voluntarism will be needed to provide the necessary lubricating force between competition and regulation and to keep either from the absurd extremes. Our continuing challenge in the health field will be to put these three forces—regulation, competition, and voluntarism—together and to refrain from seeing the world through the perspective of only the first two.

The coalition movement is, potentially, an important part of the formula. With recent significant federal government cutbacks and more likely to come, along with deregulation and decentralization, emerging human problems must be addressed at the local level, not simply by abstract formulations. Thus coalitions have a sense of urgency about them.

In my opinion, coalitions will rise or fall on the following considerations:

First, on a question of attitude. Can the generation of people in power in the health field today—a generation reared in a post-World War II ascendant economy, imbued with a spirit of expansion and faith in technology, and accustomed to low interest rates—shift gears? Can this generation look objectively at the imperatives of a maturing health market; a slowing economy; a more competitive, fragmented, and potentially internecine health environment, extremely vulnerable to double-digit inflation, and substitute for a common anger toward and fear of government takeover (e.g., national health insurance) an acceptance of selected mutual effort at the community level and in the community interest? Will this generation dedicate itself to public policy determined in part and implemented in part through a series of related but separate local decisions?

Second, will hospital trustees learn to think of the hospitals' obligation to the community, as Robert Sigmond has asked,<sup>11</sup> as the improvement of the health and well-being of the public, above all other obligations, a goal to which other institutional goals must be subordinated? Under strong trustee leadership, individual hospitals or networks of hospitals can dedicate themselves to the underserved, act as change agents in the delivery of care, and collaborate with other community health institutions to reduce disparities around the coalition table and broaden consensus. Or, hospitals can select markets, compete aggressively on all counts, ignore the concept of community, and, in the process, create unmanageable fragmentation, beyond the worth of competition. Which course of action will they select? Can hospital repre-

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<sup>11</sup>For an excellent discussion of the hospital trustee role, see Robert M. Sigmond, "Community Health Coalition—Trustee Leadership Role" (paper presented at the American Hospital Association Conference, Philadelphia, August 31, 1981).

sentatives be given authority to commit in coalitions?

Third, will carriers, including in particular HMOs and Blue Cross Plans, fight against excessive selective underwriting, play a change-agent role (e.g., foster incentive reimbursement, not pay for inappropriate care or care at inappropriate sites), resist cost sharing as a paramount solution (i.e., use it selectively), and establish provider relations capabilities sufficient to deal with hospitals on an individual basis, to minimize selection and fragmentation problems and add the discipline of finance as a counterweight to regulation?

Fourth, will area-wide planning provide coalitions with area-wide goals and other reference points and with a regulatory backup?

Fifth, will industry use its buying power judiciously in the community interest, not simply in its self-interest; give 2-5 percent of pretax income to community efforts, including health services (valuable innovative capital), in effect, stop extending to stockholders *all* the largess; and stop viewing hospitals, doctors, and Blue Cross Plans as adversaries (and thus encouraging adversary relations)?

Sixth, will health trade associations respond only to institutional interests versus public interests, becoming victims of cluttering and overextensions, or will they help set the tone of community interest?

Seventh, will government be put in proper perspective by the private sector in accepting the need for selected government programs and the limits of private and voluntary effort? Will both government and the private sector accept the need for a partnership? Will government representatives, cognizant of the limitations of government, seek membership in coalitions and learn to act in both the community and the government interest, (not, paradoxically, always the same)?

Finally, will coalitions learn to avoid the temptation to implement programs and stick to a facilitating role, thus avoiding polarization?

If the answers to these and allied questions are largely yes, if each participant does not wait for the others to reform first, coalitions can do a lot of good, they will have substance and permanent worth, rather than being simply cosmetic. However, the task will not be easy. In the context of urban policy in general the difficulty is apparent: The Reagan administration has called for bold leadership in "self-reliant" cities, while the mayors call for increased federal assistance.<sup>12</sup> The price of a pluralistic health system is high—a generous amount of local effort and initiative at the grass roots is needed for it to work. Voluntarism, as one main element, cannot be a patch. It must be a major supporting force if coalitions are to be successful.

If the answers are largely no, coalitions will pass in the night as low-risk efforts of the frustrated.

Another nagging question remains: Should coalitions be confined to health services or made inclusive of all or most community concerns? Recently, the 1981 annual report of the Committee for Economic Development summoned "urban America to develop strong working partnerships between the public and private sectors," to encourage "civic entrepreneurs" who can apply entrepreneurial skills to projects that benefit a community.<sup>13</sup> The committee favored an inclusive address to community problems, while recognizing that improvement of social and economic conditions in communities is a "goal tied closely to . . . bottom-line interests."

While the committee's exhortations are to be applauded, it is probably best that the scope of coalitions be determined locally, reflecting vary-

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<sup>12</sup>John Herbers, "Reagan Urban Report Says Federal Aid Has Hurt Revival of Cities," *International Herald Tribune* (June 21, 1982), p. 4.

<sup>13</sup>Committee for Economic Development, "Private Initiative in the Public Interest," Annual Report 1981.

ing conditions and with effectiveness the primary concern. In many medium to large communities, the decision will be difficult. Most contain thousands of community programs of differing predilections and sizes. The compromises necessary to find common ground could be exhaustive. However, more community representation can bring more community support and determination, and there are, of course, common problems in the areas of education, welfare, health, transportation, and so forth. Perhaps the best compromise would be a kind of holding company with a big heart and a lean staff, flexible and nimble enough to take periodic stock of public and private initiatives, act as a catalyst, stimulate innovation, give periodic visibility to accomplishments, and convene groups selectively, without compromising specially focused coalitions.

In essence, health coalitions are not a take-over idea or a substitute for planning. They are a concept for all times with new and visible components of appropriateness and urgency in these times. Even though modest in budget and staff and free of normal institutional constraints, which way coalitions go will tell us a great deal about what kind of health care system our society seems to want.

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