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UpDate

UpDate is a section that will report developments in health policy issues, personnel actions and scheduled conferences of relevance to the field. Because of space limitations, this first issue’s section is devoted to reporting on conferences that have been held at Project HOPE over the last year.

Development of Programs for Disabled Children and Their Families: International Strategies
Project HOPE Institute for Health Policy Seminar
November 2-5, 1981

At least one in every ten persons in the world is affected with a disabling condition. The proportion is higher in the developing regions of the world, where endemic diseases, malnutrition, poverty, and poor health generally increase the risk of mental, physical, and neurological impairment. There is great need for many types of assistance, training, and prevention, including education of the families, in order to produce a more fruitful life for handicapped children. Few communities provide the services needed to alleviate the pain and isolation brought on by disability. Disabling conditions often are not prevented nor treated. Although generally educable, disabled children are often neither educated nor enabled to participate fully in society, and the cycle of isolation and dependence is continued. The affected person and the community suffer from this waste of human potential. Two-thirds of the world’s 500 million disabled persons receive no special education or service. Most of these persons live in developing countries.

The seminar on developing programs for disabled children was convened to capitalize on the expanded awareness of problems of the handicapped during the International Year of Disabled Persons.

The HOPE Institute symposium brought together a select group of experts in child medical care, special education, and rehabilitation to discuss new program approaches and planning strategies with child care leaders from a dozen developing countries.
The primary goal of the conference was to share knowledge and develop plans to create and implement programs for training personnel and delivering services to disabled children and their families. Seminar Chairman Dr. William K. Frankenburg, Director of the John F. Kennedy Child Development Center at the University of Colorado, noted that the specific objectives of the four-day meeting were well met. These were: to prepare a general strategy, adaptable to the needs of all communities and nations, and applicable to developing comprehensive and coordinated education and health programs for the disabled child; to exchange descriptions of practical and effective models for delivering services to disabled children and their families; to assist participants in developing strategies for implementation of new programs; and to establish an ongoing communication network.

Francine Tishman, Technical Support Program UNICEF, reported on the substantial progress made in the UN agencies perspective of special education plans, especially at the UNESCO conference in Nairobi and also in UNICEF studies. She noted the sharpened focus of all efforts on early detection, and early intervention and remediation programs, as well as greater emphasis on integrated education of the handicapped.

A dozen planning and strategy papers were discussed, covering topics such as strategic processes, family involvement, UNICEF’s changing approaches to child aid, disability prevention, and training of field workers by use of satellite telecommunications. Additional papers, describing services or training in developing nations were the subjects of discussion and project planning.

Prof. John S.R. Golding of the University of the West Indies, made very clear the need for careful advance planning of a project that will rehabilitate the handicapped child, in order to assure its success. He noted that “we who work in this field know that it is our prime concern to dive deep into our patient’s potential talents until we have succeeded in developing their hidden abilities so that they can wholly or partly compensate for their disability.”

The program papers reinforced Dr. Golding’s statement, concentrating on projects that are potentially useful in other parts of the world. For example, Dr. Zygmunt Lazowski described a Polish rehabilitation center for adolescents disabled as a result of rheumatoid arthritis, and Dr. Romeo Rodriguez detailed the processes of establishing early identification and treatment programs in Mexico. Maria Teresa de Arrunategui and Joao Azevedo detailed the processes involved in establishing programs for training specialized professionals in mental retardation work in Brazil, Dr. Abiose Lasaki of Nigeria and, from the other side of the world, Dr. Phoebe Williams of the Philippines, noted the similarities and the differences in establishing and applying screening tests in their
different cultural settings. Other program initiators from Kenya, India, Jamaica, Barbados, and Peru presented adaptable case histories. All of the papers were oriented to developing a strategy handbook, under the general direction of vice-chairman Dr. Allan Abeson of the Council for Exceptional Children; Dr. Maynard Reynolds, Director of the National Support Systems Project; and University of Minnesota Professor John Bryson.

The Role of Major Medical Clinics in Meeting Future National Health Needs
Project HOPE
Institute for Health Policy Seminar
March 11-13, 1981

The conference was organized to probe significant problems faced by major private medical clinics of the United States and to consider appropriate solutions. The forty-one symposium participants developed recommendations designed to improve these special “tertiary care and clinical research” institutions’ capabilities for providing enhanced services. The topics addressed were health care economics and manpower, patient diagnostic and specialized care, research and technology assessment, and medical education. A futurist perception of health care provided a basis for developing planning guidelines. Clinics dwell in an age of great change—economic, technologic, social, and political—all of which affect these institutions.

The highly organized, multispecialty group medical clinics are in the forefront of specialized care. They carry proud names such as Mayo, Lahey, Ochsner, Geisinger, Mason, Scripps, and the Cleveland Clinic. They are truly “national health resources,” concluded the participants in the two-and-one-half-day symposium.

Economists, and leaders from business, the insurance industry, scientific research, government, the medical professions, and academia, discussed issues with leaders from seven clinics. They talked about major health care issues, including the coming of “competition” to the health care market place. They examined the predicted glut of physicians and the force it may exert on the balance of power among the suppliers, various intermediaries, and consumers. They considered the clinics’ role in research and the assessment of new medical technology at a time when the federal research dollar is shrinking. They examined the high cost of medical education, from medical school through residency training, and asked what role the clinics should play in its financial support.

As Dr. W. Eugene Mayberry, Chairman of the Mayo Clinic noted, “the
leading clinics’ structure and stability can be likened to that of a tricycle, the large driving wheel being a full range of patient care, ably supported by two smaller wheels of education and research.” But, asked Dr. Donald S. Fredrickson, who at the time was director of the National Institutes of Health, “Is it necessary that you have science within your house . . .?” Answering his own question, he said, “I would guess that with the movement of today’s science there is such a promise of accelerated pace in technology that you cannot maintain your product without interpreters there to determine which of the new technologies that will be coming out in a cascade, should be used, and how they are to be used.” Of all types of research, there was general agreement on the potential role for clinics in the assessment of present and future technology. “The private clinics represent an important resource,” stated David Banta, health program manager for the Office of Technology Assessment, U.S. Congress. “They have a cadre of specialized physicians ready to participate in tests of technologies. They want to be, and often are, at the cutting edge of medical change.”

Professors Uwe Reinhardt of Princeton and J.B. Silvers of Case Western Reserve University foresaw greater competition for hospitals and clinics alike. The competitiveness of the health care industry will change through new and cheaper substitutes for care developed by research, by additional exercise of power on the part of the consumer, and by the entrance of new types and added numbers of providers. The answer for the clinics lies in continuing to emphasize high quality specialty care, which Silvers believes can be competitive, especially with the industrial corporate world becoming more aware that it buys increased productivity for its workers when it buys quality health care.

The future of educational programs, the second small wheel on the tricycle, was the focus of much discussion at the symposium. Today, the major medical clinics are training 1500 graduate physicians, support almost 300 in research training programs, and provide all or some of the medical training for 1200 students. In addition, the seven clinics represented at the conferences last year provided continuing medical education for 13,000 physicians who attended clinic courses. Clinics must constantly reshape the size and type of residency to reflect national shortages and surpluses. Yet, Dr. August Swanson of the Association of American Medical Colleges reminded the seminar participants that in the major clinic setting, one must have a balance of training experience and educational experience, and that “it is important to remember the hazard that an optimal approach in one setting, or for one purpose, may not necessarily be optimal in every other setting.”

The conference concluded that there is, indeed, a future for the medical clinics. But they must develop a more strategic planning
capacity. They must make key decisions on their role in research and education. And they must make special efforts to meet the needs of an aging population. Dr. Charles Edwards of Scripps Clinic and former assistant secretary for health in the Department of Health, Education and Welfare, called on the clinics “to present a powerful plan . . . to prevent the kind of government action . . . that would impair the clinics’ ability to provide health care to anyone who seeks the clinics’ services.” And David Winston, Special Assistant to Health and Human Services Secretary Richard Schweiker, observed that the new administration must address “the demand for health services, for you cannot try to ratchet down supply and be effective.”

What is the future for the medical clinics? That, of course, depends in some measure upon what the future holds for society at large—continued growth or stagnation, a disciplined society, or a transformation to a more frugal and introspective way of life. On the immediate horizon, the clinics plan to take steps to meet the challenges that a less regulated, procompetition environment will give health care.

Both the complete proceedings of the papers as presented and a sixteen-page conference summary are available from the Project HOPE Institute for Health Policy, Millwood, Virginia 22646. Please send for price information on specific quantities.

Leadership Strategies–Health

Project HOPE
Institute for Health Policy Seminar
Phase I: November 19-21, 1980; Phase II: January 5, 1981

A particularly important set of national concerns was reviewed at the “Leadership Strategies–Health” symposium. The conference had a threefold purpose: to identify the range and the merits of private sector activities associated with employee health care benefits and lifestyle enhancement; to consider which programs should be promoted nationally and how such programs can be integrated and coordinated more effectively; and to prepare and present to the nation’s leaders, private and public, a set of recommendations for stimulating greater competitive activity in the health care arena.

The thrust of the deliberations was identified by Walter B. Wriston, Board Chairman of Citicorp and conference co-chairman, who emphasized that “we have reached the point where business’ expertise and skill in managing resources and enhancing market forces must be melded with the providers’ skill in caring for the sick . . . Private sector skills can help humanitarian allocation of health care resources, thus industry and
business have the opportunity to become active partners of providers in an effort to manage costs as efficiently as possible while at the same time assuring high quality care. The HOPE Institute discussions pinpoint pressure points which can be given priority and which are most likely to be successful areas for corporate action.” Co-chairman Richard R. Shinn, President of the Metropolitan Life Insurance Company, noted that “the private sector has done an outstanding job in extending the financing of medical care to a wider number of persons. . . . But it is now timely for us to look at the whole health care delivery system to see how we can make it more sensitive to the needs of the population and at the same time to minimize further intrusion of government in health care.”

Forty invited experts participated in the Phase I seminar, representing academia, government, labor, the health professions, and business. Dr. William B. Walsh, president of The People-to-People Health Foundation, directed the presentation of papers and the subsequent discussions. Topics included national health as a challenge to America’s leaders; narrowing the gaps in coverage as a joint responsibility of the private and public sectors; consumer choice and competition in the health care delivery system; pressure points for private sector action, including coalitions, physician training, and medical economics; legal issues; the role of labor; and lifestyle health promotion. Nineteen authors, each analyzing a facet of the question, presented papers.

National health care costs have risen rapidly in a few years, from $54 billion and 6.5 percent of gross national product (GNP) in 1968 to $247.2 billion and 9.4 percent of GNP in 1979. Employers will spend $63 billion in 1981 on health insurance, 47 percent more than 1978. Howard Newman, administrator of the Health Care Financing Administration at the time of the conference, said that “it seems absolutely clear to me that we are reaching the outer limits of what we can afford to pay for health services in this country.”

Added emphasis was given to procompetition health proposals, as the seminars were conducted following the national election but preceding installation of the Reagan administration. Spokesman for the new look were Senator (now Secretary of HHS) Richard S. Schweiker, and Congressman (now Director of the Office of Management and Budget) David A. Stockman. Schweiker reiterated the incoming administration’s strong commitment to competitive principles. Stockman expanded on that commitment, indicating his conviction that health care is indeed an economic good, but that today it is viewed rather as a “sort of spiritual or social or collective good.” Because of this perspective, “it is treated, regulated, and managed by society in a unique way . . . [and the] effect of that course has been to rule out all potent self-regulatory mechanisms that we rely on in almost every other market . . . and to rule out competition.
in any meaningful sense.” Stockman concluded by saying that “we have a system that is out of control. We must rethink whether . . . we can bring into play those self-regulatory, economizing, efficiency-producing mechanisms that we rely on in all other sectors.” Walter McClure, Vice-President of InterStudy, arrayed alternative strategies for inducing competition, focusing more on leadership than on legislation. Other speakers outlined programs now in operation, amenable to general adaptation and application, and successful efforts sponsored by the private sector.

The second phase of the symposium drew together executive leadership from industrial and service business corporations. Proposed courses of action developed in the first seminar were considered and twenty-five recommendations were agreed upon. The consensus was that affirmative action should be taken by the private sector to stimulate positive changes in health care. It is vital that better quality and more detailed data on employee and dependents’ health, and on utilization and cost of company health plans be made available as bases for efforts to control expenditures; such data are generally needed on a local basis. The coalition movement, especially employer coalitions, should be promoted. Better employee communications on wellness programs as well as on health care costs and benefits are needed. The consumer choice plans should be studied carefully, and experimentation conducted that will clearly identify their merits and weaknesses as well as other options.

In addition to the twenty-five recommendations from the seminars, there came a sense from the group that now is a favorable time for the private sector to initiate solutions to a set of problems that government has failed to solve, even in the face of a massive public investment in health care.

A subsequent report is separated into two volumes. Volume I consists of a summary of the meetings and abstracts of the individual presentations. Volume II reproduces the entirety of the papers as presented. Complete proceedings or additional copies are available from the Project HOPE Institute for Health Policy, Millwood, Virginia 22646. Volume I $5.00; Volume II $10.00; plus postage.

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