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American hospitals move into primary health care

A change in the payment system for inpatient acute care in the United States has brought about an increasing role for hospitals in primary health care, putting them in closer touch with the needs of communities.

Traditionally, acute care hospitals in the USA have not been very much involved in primary health care, their interest having been in developing secondary and tertiary care. Although there has been considerable movement during the last twenty years towards expanded outpatient and emergency treatment, most hospitals have seen these activities only as feeders to their inpatient beds and operating rooms. Hospitals have viewed their role as one of delivering curative services but not as being concerned with the early diagnosis and detection of disease, early intervention, the reduction of mortality, health education, or disease prevention. Although many hospitals have initiated outreach programmes and expanded outpatient activities, they had not, until recently, made significant progress in primary health care.

During the last five years, however, acute care hospitals have been undergoing major change. The tremendous rise in the cost of inpatient acute care since the introduction of the Medicare/Medicaid legislation in 1966 has produced regulatory and market responses putting a lid on hospital expenditure. Hospital costs grew by an average of more than 20% per year from 1967 to 1982. The percentage of gross national product consumed by health care rose from 5.3% in the early 1960s to 10.8% in 1983, and the average cost of a hospital bed increased from US$ 33 to $ 440 per day over the same period. Federal deficits have consequently grown and the cost of goods and services has risen because of increasing payroll costs. The result has been inflation, a stagnant economy, and increased prices of American goods in the world market place.

The government has responded with major legislative changes in the Medicare/Medicaid programmes, which were primarily intended to cover the poor and the elderly. Fixed-fee payment schedules have recently been introduced for specific diagnostic procedures or disease categories, regardless of the cost incurred by the institution providing care. This is a dramatic shift from cost-incurred reimbursement to hospitals, which became the basis of funding in 1966 *(1)*. The change in payment mechanisms has

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encouraged both physicians and hospital administrators to contain and reduce costs by discharging patients more quickly, cutting the numbers of admissions, reducing the utilization of ancillary services, and greatly expanding outpatient diagnostic and therapeutic procedures, including surgery. At the same time there has been a major change in employers' attitudes. In

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attempting to reduce the costs of products and services, certain major employers have acted with a view to controlling hospital utilization, through increased deductibles and co-payments on health insurance programmes, the screening of admissions, a requirement for second opinions on the need for surgery, the control of ancillary service utilization and of length of stay, and significant incentives for utilizing outpatient and ambulatory services.

The measures taken by government and employers have led to a decreasing demand for inpatient acute care, an overcapacity of hospital beds, and a deteriorating financial situation for most hospitals. The problem is especially acute in the large urban areas, where there are too many hospitals and most are only 50% occupied *(2)*.

Physicians

During the 1980s, the annual output of graduates from American medical schools has been twice that during the previous ten years *(3)*. Combined with an influx of foreign medical graduates, this has resulted in a surplus of physicians in most major urban and suburban areas. Meanwhile, government legislation and controls applied by employers have reduced the demand for primary and secondary care services provided by doctors.

There has also been a rapid rise of health maintenance organizations or prepaid capitation groups, delivering a full range of primary and secondary care services. This has resulted in fewer visits to physicians. The number of members of health maintenance organizations rose from 3 million in 1970 to 14 million in 1983, and more rapid increases are expected in the future *(4)*. Doctors have responded to falling incomes by forming large group practices, buying ancillary services equipment, and performing tests and procedures in their surgeries instead of sending patients to hospitals. This has resulted in a declining use of hospital outpatient ancillary facilities and in declining incomes for hospitals, which traditionally subsidized room and board provision with the relatively large profits made on ancillary services.

The patient

For acute care hospitals the physician, rather than the patient, has been the true customer, admitting and discharging patients, ordering tests, and using expensive equipment, and successful hospitals have been organized around the needs of physicians. However, with the rise of the health maintenance organizations and of preferred provider organizations, the latter usually developed by employers, the situation is changing. These organizations have many members and can shift patients from one hospital to another in response to quality, cost and service. Unlike doctors, they are interested in primary, not secondary, health care. They

utilize only a half to a third of the hospital inpatient days per capita used by traditional employers' health benefit plans. Their hospital usage rates range from 350 to 500 bed-days per 1000 members as opposed to 1000 bed-days per 1000 members for commercial insurance plans. They are interested in health education, disease prevention, screening and immunization programmes, early detection and diagnosis, and other primary health care activities. They aim to reduce acute care, bed-days and costs. Successful hospitals are listening to the new customers and developing programmes to meet their needs.

Hospital organization

Over the last ten years a major increase has occurred in the number of profit-making hospitals operated by large groups that are often international; there are now 28 profit-making multihospital systems, controlling 139 616 beds. Simultaneously, there has been a growth in voluntary non-profit multihospital systems, of which 147 now exist, with control of 177 435 beds *(5)*.

The new organizations use standardized systems, they have professional management, marketing and quality control, and they have integrated both vertically and horizontally, with the result that mergers and consolidations have taken place. They resemble large multinational holding companies, and operate not only acute care hospitals but also psychiatric hospitals, long-term care institutions, maternity centres, physician group practices, health maintenance organizations, preferred provider organizations, home health care organizations, and medical supply companies. They are developing programmes to protect their market share and meet customers' needs. With their tremendous financial resources, these institutions are making major investments in the design and development of primary health care systems *(6)*.

Primary health care

The restraints on inpatient treatment have led to an expansion of less costly outpatient procedures, both diagnostic and therapeutic. This has led to an increasing number of visits to hospital clinics and a tremendous increase in outpatient surgery.

The prepaid capitation programmes of health maintenance organizations and preferred provider organizations accomplish their objectives through strict screening of admissions and physicians' practices, utilization controls, and second opinions on the need for surgery. They are particularly concerned with health education, immunization, and early diagnosis, detection and intervention. The programmes employ midwives, physician assistants, nurse practitioners, registered nurses, physiotherapists, respiratory therapists, and other health professionals, and may focus on cardiac disease, psychological stress, or employee assistance, depending on the employer. They have significantly reduced hospitalization and the use of ancillary services. During the last five years, prepaid capitation programmes have had a major impact on hospital costs.

The tremendous rise in the cost of inpatient acute care has produced regulatory and market responses putting a lid on hospital expenditure.

Because of the decline in the demand for acute care, hospitals have been forced to protect their existing activities and to seek new ones. This has resulted in major involvement in primary health care. Acute care hospitals have begun to set up outreach programmes in which ambulatory care centres are staffed by hospital personnel but may be a long way from the hospitals. These centres are often in large buildings with a full range of diagnostic and therapeutic services. Another recent development has been the provision of small detached emergency care or urgent care centres, which are open from 6 a.m. to 9 p.m. They provide primary health care and are interested in outreach activities, including industrial and environmental medicine and home health care *(7)*. Acute care hospitals have also set up full-scale home health care facilities, staffed by doctors, dentists, nurses, physiotherapists, respiratory therapists, home health aides and other health professionals, who visit elderly or housebound people suffering from chronic diseases or dental problems or who are convalescing. Both types of activity are relatively new for hospitals and are very different from traditional acute care functions.

A most recent development in both urban and rural areas is that hospitals are now practising medicine instead of merely providing physical facilities for doctors so that they can treat patients. Hospitals are becoming deeply involved in primary health care through setting up or purchasing practices. This may mean identifying underserved areas or buying practices from retiring physicians. Younger physicians may be placed in new areas, or mid-career physicians may go into established practices. In all cases the physicians are salaried employees of hospitals *(8)*.

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Hospitals adopting the new role are beginning to see the value of health education, screening, and immunization programmes, although they are still interested in referrals to inpatient care. The trend towards primary health care in hospitals means that they will have to regard patients, not doctors, as their customers. □

References

1. **Bartlett, E. E.** *Health care financial management,* **39**: 86–94 (1985).
2. **Goldsmith, J. C.** *Can hospitals survive? - The new competitive health care market.* Homewood, IL, Dow Jones-Irwin, 1981.
3. *Profile of medical pratice.* Chicago, American Medical Association, 1980.
4. **Reisler, M.** *Harvard business review* (1985).
5. **Finkler, S. & Horowitz, S.** *Health care financial management* (1985).
6. **Johnson, E. A. & Johnson, R. L.** *Hospitals in transition.* Rockville, Aspen Systems, 1982.
7. **Macagba, R. L.** *Hospitals and primary health care.* London, International Hospital Federation, 1984. Summarized in *World health forum,* **6**: 223–229 (1985).
8. **Laubach, P. & Rand, R. L.** *Acquiring physician practices and marketing physician and joint venture services.* Malibu, CA, American College of Hospital Administrators, 1985.