HANDBOOK OF MEDICAL STAFF MANAGEMENT

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To John,
whose support never wanes
C.O.G.

To Mark
and all of my former students
S.L.

Preface

As the health care delivery system consumes more of the gross national product each year, the structure of the system as we have known it in the post–World War II era is changing. The traditional fee-for-service, physician-controlled format is evolving into many different models. Increased federal regulation has assisted in shaping this evolution, and new professions have begun to take on a greater role. One of these important new professions is medical staff services management.

Defining the new professions is a challenge that has been taken up by the federal government, accrediting bodies, and professional organizations. Whatever the final outcome, the goal is to provide the best health care at the most reasonable cost. By clearly defining its role, each profession can contribute to the efficient provision of care.

The *Handbook of Medical Staff Management* was written with the intent that it become the standard text for the evolving field of medical staff services management. Frustrated by the lack of one comprehensive written work on this important field, the editors set about gathering a group of authoritative contributors who could remedy this deficiency.

In addition to being a definitive text, this book can serve as a valuable resource for medical staff service practitioners and an aid for those preparing to earn their credentials in the field. Physicians who have assumed a leadership position in a medical staff organization but have little or no prior education in health care administration should find this text useful. It also will serve as a reference for the nonprofessional in medical staff services who wishes to learn more about this challenging area of hospital administration.

The editors gratefully acknowledge the efforts of the contributors: Without their work the book would not have been possible. Our thanks also to Aspen Publishers, which had the foresight to recognize the value of the project.

Cindy Orsund-Gassiot
Sharon Lindsey

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Part I

The Health Care Stage

All the world's a stage.

Shakespeare, *As You Like It*

Chapter 1

Health Care Delivery Systems

Janet Thompson Reagan, PhD

A BRIEF HISTORY

Health care is one of the largest industries in the United States, both in size of expenditures and persons employed. In 1987 expenditures on health care totaled $500.3 billion, or 11.1 percent of the gross national product (GNP). Expenditures for hospital care totaled $194.7 billion, followed by expenditures for physician services ($102.7 billion).[1] In 1987 hospitals employed 4,440,000 people, and over 7 million were involved in health services delivery.[2] The industry is rapidly changing in response to legal, cultural, technological, and economic developments within its environment. Terms commonly used to describe the environment include "turbulent," "unstable," and "complex."

What began as a cottage industry of individual providers has evolved into a complex array of providers, service delivery mechanisms, payment mechanisms, and regulatory agencies. Torrens described the development of the health care system according to the predominant health problem of the period, the technology available, and the social organization for applying the technology.[3] He divided the history of the industry into four periods: 1850 to 1900, 1900 to World War II, World War II to roughly 1980, and from now into the future. Other authors have used similar approaches in tracing the development of the health care system. For example, Odin W. Anderson discussed the periods from 1875 to 1930, 1930 to 1965, and 1965 to the present (1985).[4] This brief overview of the industry will begin at an earlier point, the pre-1750 era, and then will focus on the periods of development described by Torrens.

Pre-1750

During the pre–Industrial Revolution years (pre-1750), the practice of medicine was relatively primitive.[5] The scientific viewpoint was undeveloped, and medical

practice was often based on speculation, trial and error, and even superstition. Medical education was neither standardized nor regulated. Hospitals in their current form did not exist. Institutions for care were essentially pesthouses or almshouses established and run by religious organizations or, in some cases, by local governments. Medical technology and the kind of social organization required for its application were largely nonexistent.

During this period, activities focused on attempts to control epidemics, prevent the entry of new diseases, and ensure a safe water supply. For example, in 1647 the Massachusetts Bay Colony passed a regulation to prevent pollution of the Boston Harbor, and in 1701 the Commonwealth of Massachusetts passed a law requiring isolation of persons with smallpox.[6]

The Industrial Revolution (1750–1850)

During the Industrial Revolution, developments occurred largely in the area of public health. Local and state health agencies were established in response to epidemics and the need to ensure safe water supplies and adequate sanitation. Medical science advanced as a result of an increasing emphasis on logical experimentation and controlled observation. Medical training improved, beginning with the establishment of the first American medical school at the College of Philadelphia in 1765.[7] The American Medical Association was founded in 1847 and had as one of its primary goals the improvement of medical education. Yet, rigorous training was still rare. "In 1800 there were only four functioning medical colleges; in 1825 there were eighteen."[8]

Hospitals were still primarily almshouses serving the indigent. Yet toward the end of this period, hospitals began to emerge as legitimate providers of care, and not only for individuals with communicable diseases who had to be isolated and for the indigent who had no other options for care but also for individuals in the larger community who had the resources to pay.

The Shattuck Report of 1850 can be viewed as the culmination of advances in public health during this period. Although the report did not initially stimulate dramatic changes in the provision of public health services, it set out far-reaching recommendations that not only held true for that time, but continue to hold true. For example, Shattuck included recommendations regarding the control of alcoholism, smoke nuisances, routine physical examinations, and family records of illness, to name only a few.[9]

1851–1900

The period from 1851 to 1900 was characterized by only moderate progress in the medical field. Diagnostic and therapeutic techniques were improved and

anesthesia and antisepsis were developed.[10] Medical education and practice, however, were still at a low level. Although many medical schools existed, over 450 at times, many of the new schools were proprietary and curricula and programs varied widely.[11] Schools were not held accountable for the ability or the quality of the physicians produced. At the end of this period, licensure of physicians emerged as medical practice acts began to be enacted by the states in the 1870s.

Nursing emerged as the first allied health profession, and hospital-based training programs for nurses were established. Although Florence Nightingale is credited with the "transformation of nursing into a profession," it was Dorothea Dix who recruited nurses and encouraged nursing training programs in this country during the Civil War.[12] Permanent schools of nursing were established in the post–Civil War years. The health care team now consisted of the physician and the nurse.

Hospitals became legitimate providers of care. As surgery developed, the affluent sought the services of surgeons, who in turn sought to practice in hospitals. "By 1900 there were 4,000 general hospitals in the United States."[13]

1901–1945

The period from 1901 to roughly 1945 included remarkable medical advances, the expansion of state and federal subsidies for health services, the revamping of medical education, and the emergence of the framework for the health care system as it currently exists. During this period, the focus of health care shifted from epidemics to individual episodes of acute disease.[14] Support for medical research was greatly expanded, and advances were made in diagnosis, treatment, and prevention of disease. The period of antibiotics began with the discovery of penicillin in 1941. With the advances in medical science, health care professionals began to combat successfully individual episodes of acute disease.

Medical education was revolutionized as a result of the efforts of the American Medical Association, the advances in medical science, and the publication of the Flexner Report in 1910.[15] Although the number of medical schools declined as a result of the closure of substandard schools (down to 85 in 1920), those that remained built their curricula on a sound scientific base, and a four-year program of preparation became standard. Additionally, "by 1925 forty-nine boards (for medical licensure) required candidates for their examinations to be graduates of a medical college."[16] During this period, many of the medical specialties developed. Only 1 specialty existed in 1920; by 1940 there were 16.[17]

Government involvement at both the state and federal level increased. At the federal level, the Pure Food and Drug Act was passed in 1906. The Sheppard-Towner Act of 1921 made small federal grants available to state and local governments for maternal and child health programs and for the development and strengthening of local health departments.[18] Other federal action included the 1935

Social Security Act. Title V of this act increased federal assistance to maternal and child health programs and greatly expanded assistance to state and local health departments. Another outcome of this legislation was the growth in proprietary nursing homes. Guaranteed monthly incomes through old age survivors insurance and old age assistance programs enabled the elderly to pay for boarding home or nursing home care. Payments were not made to the elderly in almshouses or government facilities. Finally, the 1944 Public Health Service Act brought all the federal public health programs together under one agency.

The Committee on the Costs of Medical Care was created in 1927 through the support of private foundations.[19] A series of 27 field studies were conducted and a total of 28 reports published. The last report, published in 1932, recommended that health services be delivered through organized groups and that the costs of medical care be financed on a group basis. This restructuring of the health care system was proposed as a means of addressing economic inefficiency and reducing preventable pain and needless deaths.

It was during this period that the third-party pay system emerged as an important source of financing for health services. During the Depression, the Blue Cross and Blue Shield plans were developed to ensure that individuals would have access to hospital and physician services. The first commercial insurers also entered the marketplace, and the first prepaid group, the Ross-Loos Plan, was established.

Any attempt to summarize the medical advances during this period would be futile. Progress was made on all fronts. New diagnostic procedures developed; treatments, especially surgical procedures, were improved; and prevention of diseases, especially infectious diseases, became more successful.

1946–1965

The period from 1946 to 1965 included rapid advancement in the medical sciences, expansion of federal effort in the health care field, and the continued growth of third-party payers. "From 1947 to 1963 federal support of medical research increased at an average annual rate of 26 percent."[20] The National Institutes of Health increased in prestige and set the agenda for medical research during this period.

The role of the federal government in health services was greatly expanded. With the passage of the Hill-Burton Act (Hospital Survey and Construction Act) in 1946, the federal government began to subsidize the construction of hospitals. Between 1947 and 1971, Hill-Burton funds helped to build 345,000 hospital beds.[21] Through amendments to the original legislation, funds were later used for hospital renovations and for the construction of ambulatory clinics and nursing homes. Mental health services were supported through the 1946 Mental Health Act and later

through the 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act.[22]

The federal government also subsidized the development of human resources through a variety of programs, including the Vocational Education Act of 1946, the Grants-in-Aid to Schools of Public Health in 1958, and the Health Professions Education Assistance Act of 1963. New occupations emerged in response to the introduction of new technology and advances in medical practice. The practice of medicine became increasingly specialized.

1966–Present

The mid-sixties are considered by many to be a turning point in the health care industry. The predominant health care focus shifted from individual episodes of acute disease to chronic health conditions, partly as a result of our aging population and partly as a result of medicine's success in preventing and treating acute disease.[23]

The federal government began to play an even larger role in health services. Lawrence Brown identified the main function of the federal government from 1966 to the mid-seventies as the provision of financing.[24] With the implementation of Medicare and Medicaid in 1966, the federal government became a major source for financing of health services. Medicare is a federal insurance program for those qualifying for Social Security benefits, and Medicaid is a federal-state assistance program for the indigent.

Although a description of these programs is beyond the scope of this chapter, an indication of their impact on the health care system is essential. Expenditures for both programs soon far exceeded projected levels. Since both were entitlement programs, expenditures were difficult to project and control. Federal expenditures for Medicare alone went from $4.5 billion in 1967 to $15.6 billion in 1976.[25] For Medicaid, the federal response was to allow states to reduce covered services, restrict the eligible population, and modify reimbursement methods to control expenditures. For Medicare, the federal government sought to control expenditures through regulation and reimbursement, for example, through the introduction of professional standards review organizations (PSROs) in 1972 and the prospective payment system (PPS) in 1983.

Brown characterizes federal policy in the 1970s as one of reorganization and regulation.[26] Reorganization was seen as a way of increasing system efficiency and controlling expenditures. The Health Maintenance Organization (HMO) Act of 1973 is an example of action in this area. Additionally, Title XIX of the Social Security Act was amended to encourage the enrollment of persons covered by Medicaid in alternative delivery systems, usually prepaid groups.