American Osler Society, Inc. John P. McGovern Award Lectureship

Health Care in the Next Millennium

John D. Stobo M.D.

John P. McGovern Award Lectureships

1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.

2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans, Louisiana.

4. *The 'Open Arms' Reviving: Can we Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.

5. *Rx: Hope* presented by E. A. Vastyan, May 8, 1990 in Baltimore, Maryland.

6. *Osler's Gamble and Ours: The Meanings of Contemporary History* presented by Daniel M. Fox, April 10, 1991, in New Orleans, Louisiana.

7. *From Doctor to Nurse with Love In a Molecular Age* presented by William C. Beck, March 26, 1992, in San Diego, California.

8. *The Heroic Physician In Literature: Can The Tradition Continue?* presented by Anne Hudson Jones, May 12, 1993, in Louisville, Kentucky.

9. *'The Leaven of Science': Osler and Medical Research* presented by David Hamilton, May 10, 1994, in London, England.

10. *A Body of Knowledge: Knowledge of the Body* presented by Sherwin B. Nuland, May 10, 1995, in Pittsburgh, Pennsylvania.

11. *Other People's Bodies: Human Experimentation on the 50th Anniversary of the Nuremberg Code* presented by David J. Rothman, April 25, 1996, in San Francisco, California.

12. *The Coming of Compassion* presented by Roger J. Bulger, April 3, 1997, in Williamsburg, Virginia.

13. *Why We Go Back to Hippocrates* presented by Paul Potter, May 6, 1998, in Toronto, Ontario

14. *Health Care in the Next Millennium* presented by John D. Stobo, M.D., May 5, 1999, in Montreal, Canada.

Cover — Obverse and reverse sides of John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

The Fourteenth John P. McGovern Award Lecture

Health Care in the Next Millennium

by

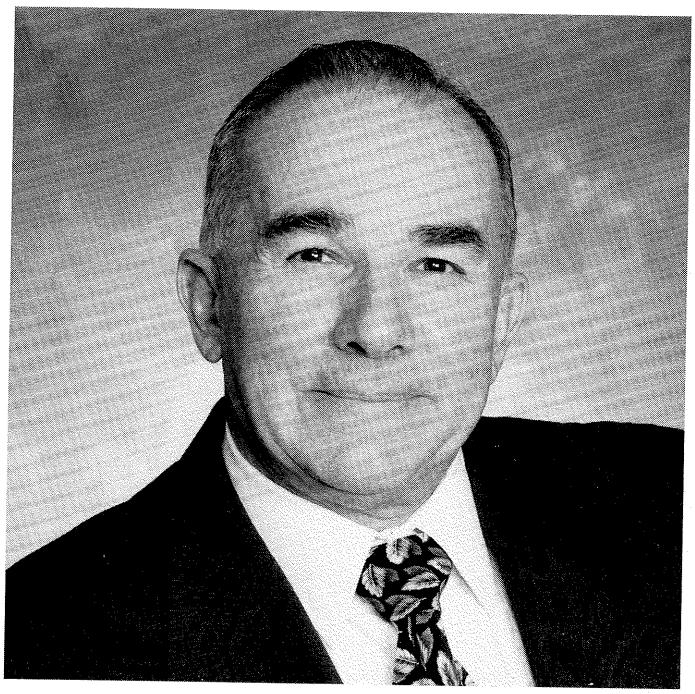
John D. Stobo, M.D.

Delivered 5 May 1999 at the
Twenty-Ninth Annual Meeting of
the American Osler Society
Montreal, Canada

John P. McGovern, M.D.

JOHN P. McGOVERN AWARD LECTURESHIP

Through the generosity of the John P. McGovern Foundation to the American Osler Society, the John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences—in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own long-standing interest in and contributions to Osleriana.



John D. Stobo, M.D.

JOHN D. STOBO

Dr. John D. Stobo received his B.A. from Dartmouth College and his M.D. from the State University of New York at Buffalo. He completed an internship and assistant residency and served as chief medical resident on the Osler Medical Service of the Johns Hopkins Hospital in Baltimore.

After serving on the faculties of the Mayo Clinic and the Howard Hughes Medical Institute at the University of California, San Francisco, Dr. Stobo returned to Baltimore in 1985. A specialist in rheumatology and immunology, he served as the William Osler Professor of Medicine and director of the Department of Medicine at the Johns Hopkins University School of Medicine. He also served as physician-in-chief of the Johns Hopkins Hospital.

In July 1994, Dr. Stobo was chosen to lead the new Johns Hopkins HealthCare LLC, which was charged with developing an integrated delivery system on behalf of Johns Hopkins Medicine. In June 1997, he was also named vice dean for research and technology for the Johns Hopkins University School of Medicine.

In September 1997, Dr. Stobo was named president of the University of Texas Medical Branch at Galveston, Texas' oldest health sciences university. He has been instrumental in bringing diverse areas of the university together to define UTMB's core values and shape its future as a leading center for health sciences education, medical research and patient care.

Dr. Stobo is a member of the Institute of Medicine, chairing its board on health sciences policy. He is the past president of the American College of Rheumatology, past president of the Association of Professors of Medicine and past chairman of the American Board of Internal Medicine. In 1996, he received a mastership from the American College of Physicians for his distinguished contributions to internal medicine.

Dr. Stobo and his wife, Mary Ann, have three children—John, Robert and Heather—and three grandchildren.

It is an honor to present the John P. McGovern lecture at this, the 1999 American Osler Society annual meeting, and to be before this distinguished group.

Shortly after arriving in Galveston approximately 18 months ago, I had the pleasure of meeting Jack McGovern. I soon learned that we share more than a first name. We share a commitment to the Oslerian principles of professionalism and, more importantly, a concern that these principles are under assault in a rapidly changing health care environment. Mention of medicine as a business, health care as a commodity, physician unions, and patients as covered lives gives credence to that concern. This concern serves as the impetus for my presentation to you: Health Care in the Next Millennium. What should the health care environment look like in the 21st century in order to preserve the principles of professionalism? What needs to be done to assure society that, as health professionals, we are acting in their—and not our—best interests? In other words, I would like to present my thoughts about changes that need to occur in the behavior of health professionals to reaffirm their commitment to serving the health needs of society.

To those of you who are waiting to hear specific prognostications on what reimbursement methodologies will be present in the future, whether or not everyone will carry their medical record on a smart card, or whether or not we will have a genetic profile of disease susceptibility determined at birth, I am sorry to say you will be disappointed. I am not going to talk about such specific changes. Instead, I will present general concepts to frame a health care environment in which the concepts of professionalism can flourish.

Before discussing the future, it is necessary to talk about the past: where medicine has come from. Indeed, American medicine has come a long way in the past 100 years.

At the turn of the last century, medicine in the United States hardly was struggling as a profession. The Flexner Report of 1910 pointed out that there were too many medical schools training too many physicians who were ill equipped to not only deal with the afflictions of society, but

also to exemplify the tenets of professionalism (1). The Flexner Report stated, "The medical professional has become diluted with practitioners of low ideals and professional honor." The report called on medical leadership to restore the principles of professionalism when it stated, "Those who represent the higher ideals of the medical profession must take a stand for that form of education calculated to advance the true interests of society and to better the ideals of medicine itself."

Fortunately, there was leadership in American medicine—William Osler being most prominent—which did re-set the moral compass for medicine. The last 100 years have been characterized, until most recently, by advances that have enhanced the professional status of medicine. But, as I mentioned, now, as we approach the next century, the professional status of medicine faces significant challenges analogous to the situation that confronted medicine as it entered into this century.

What about the future? What should occur in the health care environment to preserve medicine's professional status?

The new health care environment should be framed by three concepts: community, collaboration, and curriculum—alliteration to frame a community-centric, cooperative health care system addressing health care needs and educating health professions students for tomorrow's medicine.

Community

The first concept to shape the new health care environment is community. In discussing the challenges faced by academic health centers and health sciences universities in the United States, I believe that only those entities that are viewed as adding value to the health of the communities they serve will indeed be successful in the future. In order to survive in the 21st century, health sciences universities will require public support. They will not get this support unless the geographic community they serve views them as adding value to the health of that community. Health sciences universities must be viewed as a community resource. Indeed, in the future, all health-related activities must move from egocentric entities to a community-centric coalition (2). They must ask what is best for the community, not what is best for the individual entity. I feel that health sciences universities should be leaders in promulgating this community-centric orientation and organizing these community-centric coalitions.

This concept has several important implications. The coalition must have a governance structure that allows it to function as a community cooperative, with enlightened, dedicated community citizens making decisions as stewards of the health of the community. The bottom line will be the measured health status of the community and not the balance sheet of the hospital or other health-related entity. Chief executive officers, presidents and other executive leaders will be judged by their ability to enhance the health status of the community and not by the profits and losses in their individual health care enterprise. The question will be what is ethical, not what is profitable. The individual health-related enterprises and the aggregate coalition must be viewed as being advocates for the unmet health needs of the community.

In the United States, there are some examples presently of health-related entities that are community-centric and do have the governance structure of a community cooperative. For example, there is a group of approximately 600 community clinics scattered throughout the country that are committed to addressing the unmet health needs of the community. They receive some support from the federal government. These federally qualified health centers are mandated to have at least 51 percent of their board made up of directors who utilize their services. I have worked with several federally qualified health centers and witnessed their community commitment. I have participated in their governance structure and seen the enormous benefit this structure brings to the center's ability to address community heath needs.

I submit that such a community cooperative governance structure, in the future, will be important for the oversight of health sciences universities. Rather than a board of directors or trustees, consisting of intelligent, well-meaning and successful individuals who are selected predominantly because of their wealth and influence, the governance structure will change to consist of equally capable, local, community citizens. Only in this way will health sciences universities be seen as truly reaching out to address community health needs.

In this world of community-centric health care, there will be a painful clash of cultures and values as health-related institutions and their community boards make decisions about how to best allocate resources to ensure the greatest health care benefit to the largest number of individuals. They must move painfully from the traditional ways of making decisions based on wanting everything for each individual patient to a paradigm in which decisions are based on how to use the available resources

to provide the greatest good to the most people. The community rather than a single individual will become the "patient." A community-centric health care system will understand that advancing the health status of the community involves more than traditional health professionals and traditional delivery sites (2). Preventive and health maintenance strategies and changes in lifestyle to advance health status cannot occur without the participation of a variety of health professionals and advanced-degree caregivers. While physicians play an important role in the health care delivery system, they will be part of a team including nurses, midwives, allied health professionals, public health officials, educators and others.

The community-centric health care system will utilize existing community resources and facilities instead of requiring more and building new ones. The system will realize that a church or school can be a primary care clinic or screening site (2).

Collaboration

In order for the community-centric health care system to work, it must embrace a second concept: collaboration. The health care environment must move from the present paradigm of competition to the new paradigm of collaboration. If health care is going to be community-centric, then all health providers, health facilities and agencies in the geographic community must come together in a coalition to take what is a fragmented, duplicative, inefficient, wasteful and expensive health care system and transform it into a coordinated, efficient and cost-effective system to address community health needs.

Included in this coalition will be traditional health care providers as well as other disciplines and agencies that can have an impact on health needs but heretofore have not been part of the traditional health care mainstream. This includes schools, churches, transportation agencies, housing authorities, social services and others (2). Hospitals, which previously, through the paradigm of competition, have added costs to health care by replicating facilities and services, will come together to rationalize these same facilities and services in the context of what is best for the community, not what is best for the bottom line. In my opinion, there is no room for investor-owned health care providers or payors in such an environment. Fiduciary responsibility of the community-centric health system is to the health status of the community, not the financial betterment of shareholders. The community will not allow 10 to 15 cents of

each health care dollar to be sent to Wall Street when it can be best used locally to address health needs.

In selected areas of the United States there has already been some movement toward this new paradigm of cooperation instead of competition. This is being driven not only by the rising cost of health care and the realization that it is no longer financially possible to replicate costly facilities, technology and services, but also by the rapid increase in the United States of people who do not have health insurance—private or public—and cannot afford to pay for their care. Let me explain.

In the United States, beginning in the mid-1980s, there began an erosion in employer-based health insurance driven by yearly, near double-digit increases in health care costs. As health care costs and the costs of premiums increased, employers found it increasingly difficult to cover the cost of health insurance. They either stopped providing health insurance as an employee benefit or passed these costs on to employees. Employees, in turn, were not able to absorb these costs and stopped carrying health insurance. The result is that presently 15 percent of the U.S. population under the age of 65—roughly 46 million Americans—cannot access the health care they need simply and solely because they lack heath insurance and cannot afford to pay for their care (3). Even if they do get access to health care through emergency rooms and free clinics, it is fragmented, uncoordinated, and lacks emphasis on heath maintenance and prevention. Today, the number of uninsured in the United States is increasing by 1.5 million individuals each year.

The traditional health safety nets in the United States, particularly health sciences universities and their teaching hospitals, which provide 40 percent of the unsponsored care in the nation, are unable to accommodate the increasing number of uninsured (4). This challenge of providing free care to the uninsured is therefore spilling over to health care entities that previously have not seen this as their problem. This situation is now having a negative financial impact on these entities, as well as the entities and agencies that traditionally have provided unsponsored care. Health-related facilities in specific geographical communities are now realizing that only by coming together in a cooperative coalition of health care providers and addressing the health needs of everybody in the community will they be able to weather the financial challenges of rising health care costs and the increasing number of uninsured. Let me provide a couple of examples.

Recently, I met with an executive of an investor-owned hospital in

Texas. This executive related that there had been recent discussions with the executive leadership of a city-owned hospital that has historically served as a medical safety net for the community's unsponsored patients. The topic of the discussion was how both entities could work together to address the health needs of the community, including the uninsured. To me, this seemed to be an unlikely partnership, and when I asked why these discussions were taking place, the response was, "Because the numbers don't make sense anymore." In other words, because the balance sheets of both hospitals were suffering, leaders of both institutions realized that the survival of each required working together to address the financial concerns and the issue of providing health care to unsponsored patients. I predict this partnership, driven initially by financial motives, will be sustained by other, more altruistic ones.

A second example of a community-centric cooperative health system addressing unmet community health needs is a model system in the county of Hillsborough, Florida. In 1992, a coalition of providers in Hillsborough—consisting of five hospitals, one university medical association, two federally qualified health clinics, and a panoply of community providers and community services—came together to develop a health plan to provide health care to the uninsured of the county (5). They started with a budget of $48 million (raised initially from an increase in the sales tax of a 1/2 cent). The plan initially provided health care to 28,000 uninsured. Five years later the plan had increased its enrollment to 50,000, with an increase of only $6 million in expenses. In five years, the plan had decreased the per-enrollee cost of delivering health care from $600 to $202 per month, decreased the number of admissions per 1000 enrollees from 134 to 12, decreased emergency room costs by $10 million, and had financial reserves of $156 million. Because the coalition was so successful financially, the needed sales tax was decreased from 1/2 to 1/4 of a cent. Most importantly, the health status of the uninsured population, which initially had been significantly worse than that of the general population, was indistinguishable at the end of the five years from the health status of the general population.

This is a remarkable example of how a community of previously competitive health professionals and entities came together in a community-centric collaboration to address the problem of unsponsored care. In doing so, they decreased costs and improved the health of the community they served. I predict that soon the Hillsborough plan will need no additional tax subsidy. Instead, by controlling costs through appropriate

utilization of health services and by increasing the health status of the community, they will be able to function using existing financial resources. Herein lies another important point. The environment of community-centric, collaborative health care, which will characterize the future, will result in a slowing of the yearly increases in health care costs.

Curriculum

The third concept framing the environment for the future is represented by the term curriculum. In order to meet the health needs of the community, the way we educate future generations of health professionals must change. In order to support a community-centric, cooperative health care environment, the curriculum should include topics that range from how to work as part of a cooperative venture to how to effectively address health needs of the community (6). Topics related to teamwork, information management, continuous quality improvement, behavioral modification, health maintenance, prevention, efficient utilization of resources to address health needs of populations, ethics, spirituality in medicine, palliative care, end of life care—which are all making their way into traditional curricula for health professionals—will become core components of education in the health professions. Much of what is now termed alternative or complementary medicine will be demonstrated to contribute to a healing environment and included in the mainstream of therapeutics. The operative for determining how to approach a health issue will move from "do it right" to "do the right thing." Outcomes, quality and what is best for the greater community will become benchmarks for success.

In addition to changing the curriculum used to educate health professionals for tomorrow's world, the way they are educated will change. Approaches that educate students as individual health professionals will not prepare them for the cooperative approach to health care. Classrooms of the 21st century will be virtual classrooms, educating diverse health professions students as a team so that they can learn from each other as they come to understand that what the team contributes to the health of the community far exceeds the sum of what each contributes individually.

If there is to be a centennial repeat of the Flexner Report, it should examine how health professionals and entities, including health sciences universities, have come together to address the health needs of their com-

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munities. It should point to models, including health sciences universities that have developed model curricula and methods for educating teams of individuals to address health needs. Hopefully, the next Flexner Report will describe not only model experiments, but showcase health sciences universities that have led the formation of community-centric coalitions to better the health status of the community.

I began this presentation by commenting on how far American medicine has come in this century. As we now turn from this into the next century, there are certain similarities between the environment now and that which existed as medicine transitioned from the 19th to the 20th century. Medicine in the United States, now as then, is in turmoil. Like then, we seem to be in a transition of chaos and crisis. In the last transition, Flexner pointed the way by showcasing institutions in the United States that represented examples of what medical education, research and clinical care should look like. The centennial Flexner Report should focus on communities and health sciences universities that have moved from a position of self-interest and competition to one in which what matters most are the interests and well-being of the community. This Flexner Report will be the blueprint for our ability to sustain the principles of professionalism. Those we serve will indeed understand that we as health professionals are acting in their best interests.

I want to thank you for the privilege of coming before you and I especially want to thank Jack McGovern, not only for his generous support of American medicine but also for reminding us that, in the words of Osler, "We are in this profession as a calling, not as a business; as a calling which extracts from us at every turn self-sacrifice, devotion, love and tenderness to our fellow man. We must work in the missionary spirit with a breath of charity that raises us far above the petty jealousies in life." (7)

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