The Case of the Unhealthy Hospital

by Anthony R. Kovner

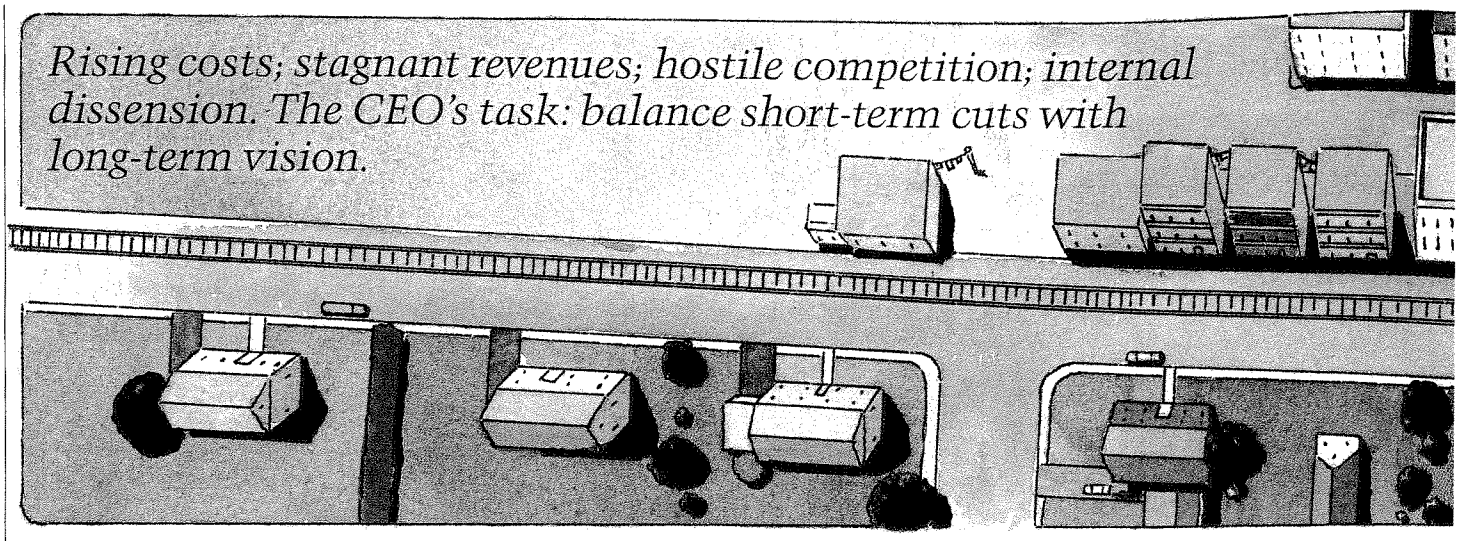
Harvard Business Review

No. 91506

Harvard Business Review

SEPTEMBER-OCTOBER 1991

Rising costs; stagnant revenues; hostile competition; internal dissension. The CEO's task: balance short-term cuts with long-term vision.



The Case of the Unhealthy Hospital

by Anthony R. Kovner

Bruce Reid, Blake Memorial Hospital's new CEO, rubbed his eyes and looked again at the 1992 budget worksheet. The more he played with the figures, the more pessimistic he became. Blake Memorial's financial health was not good; it suffered from rising costs, static revenue, and declining quality of care. When the board hired Reid six months ago, the mandate had been clear: improve the quality of care and set the financial house in order.

Reid had less than a week to finalize his $70 million budget for approval by the hospital's board. As he considered his choices, one issue, the future of six off-site clinics, commanded special attention. Reid's predecessor had set up the clinics five years earlier to provide primary health care to residents of Marksville's poorer neighborhoods; they were generally considered a model of community-based care. But while providing a valuable service for the city's poor, the clinics also diverted funds away from Blake Memorial's in-house services, many of which were underfunded.

As he worked on the budget, Reid's thoughts drifted back to his first visit to the Lorris housing project in early March, just two weeks into his tenure as CEO.

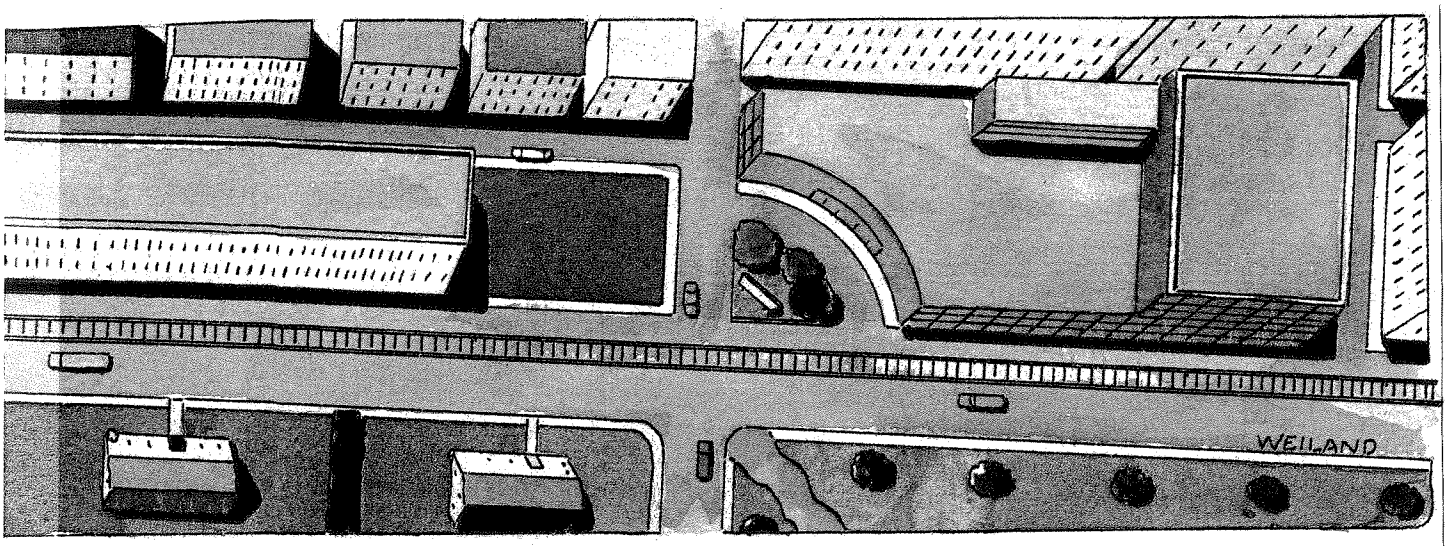
The clinic was not much to look at. A small graffiti-covered sign in the courtyard pointed the way to the basement entrance of an aging six-story apartment building. Reid pulled open the heavy metal door and entered the small waiting room. Two of the seven chairs were occupied. In one, a pregnant teenage girl listened to a Walkman and tapped her foot. In the other, a man in his mid-thirties sat with his eyes closed, resting his head against the wall.

> The clinic was in critical condition. Fifteen years as a hospital administrator had not prepared Reid for this.

Reid had come alone and unannounced. He wanted to see the clinic without the fanfare of an official visit and to meet Dr. Renée Dawson, who had been the clinic's family practitioner since 1986.

The meeting had to be brief, Dawson apologized, because the nurse had not yet arrived and she had patients to see. As they marched down to her office, she filled Reid in on the waiting patients: the girl was 14 years old, in for a routine prenatal checkup, and the man, a crack addict recently diagnosed as HIV positive, was in for a follow-up visit and blood tests.

Anthony R. Kovner is professor of health policy and management at the Robert F. Wagner Graduate School of Public Service at New York University. He is the author of numerous books and articles on health care management, including Really Managing: The Work of Effective CEOs in Large Health Organizations *(American College of Health Care Administrators, 1988).*



On his hurried tour, Reid noted the dilapidated condition of the cramped facility. The paint was peeling everywhere, and in one examining room, he had to step around a bucket strategically placed to catch a drip from a leaking overhead pipe. After 15 years as a university hospital administrator, Reid felt unprepared for this kind of medicine.

The conditions were appalling, he told Dawson, and were contrary to the image of the high-quality medical care he wanted Blake Memorial to project. When he asked her how she put up with it, Dawson just stared at him. "What are my options?" she finally asked.

Reid looked again at the clinic figures from last year: collectively they cost $1.1 million to operate, at a loss of $256,000. What Blake needed, Reid told himself, were fewer services that sapped resources and more revenue-generating services, or at least services that would make the hospital more competitive. The clinics were most definitely a drain.

Of course, there was a surfeit of "competitive" projects in search of funding. Blake needed to expand its neonatal ward; the chief of surgery wanted another operating theater; the chief of radiology was demanding an MRI unit; the business office wanted to upgrade its computer system; and the emergency department desperately needed another full-time physician. And that was just scratching the surface.

Without some of these investments, Blake's ability to attract paying patients and top-grade doctors would deteriorate. As it was, the hospital's location on the poorer, east side of Marksville was a strike against it. Blake had a high percentage of Medicaid patients, but the payments were never sufficient to cover costs. The result was an ever-rising annual operating loss.

Reid was constantly reminded of the hospital's uncompetitive position by his chief of surgery, Dr. Winston Lee. "If Blake wants more paying patients – and, for that matter, good department chiefs – it at least has to keep up with St. Barnabas," Lee had warned Reid a few days ago.

Lee complained that St. Barnabas, the only other acute-care hospital in Marksville, had both superior facilities and better technology. Its financial condition was better than Blake's, in part because it was located on the west side of the city, in a more affluent neighborhood. St. Barnabas had also been more savvy in its business ventures: it owned a 50% share in an MRI unit operated by a private medical practice. The unit was reportedly generating revenue, and St. Barnabas had plans for other such investments, Lee had said.

> "If Blake wants more paying patients and good doctors, it has to keep up with the competition," insisted Dr. Lee.

While Reid agreed that Blake needed more high-technology services, he was also concerned about duplication of service; the population of the greater Marksville area, including suburban and rural residents, was about 700,000. But when he questioned Richard Tuttle, St. Barnabas's CEO, about the possibility of joint ventures, he received a very cold response. "Competition is the only way to survive," Tuttle had said.

Tuttle's actions were consistent with his words. Two months ago, St. Barnabas allegedly had offered financial incentives to some of Marksville's physicians in exchange for patient referrals. While the rumor had never been substantiated, it had left a bad taste in Reid's mouth.

Reid knew he could either borrow or cut costs. But the hospital's ability to borrow was limited due to an already high debt burden. His only real alternative, therefore, was to cut costs.

Reid dug out the list of possible cuts from the pile of papers on his desk. At the top of the page was the heading "internal cuts," and halfway down was the heading "external cuts." Each item had a dollar value next to it representing the estimated annual savings.

Reid reasoned that the internal cuts would help Blake become a

DRAWING BY GARISON WEILAND

leaner organization. With 1,400 full-time equivalent employees and 350 beds, there was room for some cost cutting. Reid's previous hospital had 400 beds and only 1,300 FTE employees. But Reid recognized that cutting personnel could affect Blake's quality of care. As it was, patient perception of Blake's quality had been slipping during the last few years, according to the monthly public relations office survey. And quality was an issue that the board was particularly sensitive to these days. Eliminating the clinics, on the other hand, would not compromise Blake's internal operations.

Internal Cuts

Cut 2% nursing staff: $340,000
Cut 2% support and ancillary staff: $290,000
Cut maximum 3% from business office staff: $50,000
Freeze all wages and salaries at 1991 level: $1.5 million
Eliminate weekly in-house clinics: $100,000

External Cuts

Eliminate all off-site clinics: $256,000

Everyone knew the clinics would never generate a profit for Blake. In fact, the annual loss was expected to continue to climb. Part of the reason was rising costs, but another factor was the city of Marksville's ballooning budget deficit. The city contributed $100,000 to the program and provided the space in the housing projects free of charge. But Reid had heard from two city councilmen that funding would likely be cut in 1992. Less city money and a higher net loss for the clinic program would only add to the strain on Blake's internal services.

Reid had to weigh this strain against the political consequence of closing the clinics. He was well aware of the possible ramifications from his regular dealings with Clara Bryant, the recently appointed commissioner of Marksville's health services. Bryant repeatedly argued that the clinics were an essential service for Marksville's low-income residents.

"You know how the mayor feels about the clinics," Bryant had said at a recent breakfast meeting. "He was a strong supporter when they first opened. He fought hard in City Hall to get Blake Memorial the funding. Closing the clinics would be a personal blow to him."

Reid understood the significance of Bryant's veiled threat. If he closed the clinics, he would lose an ally in the mayor's office, which could jeopardize Blake's access to city funds in the future – or have even worse consequences. Reid had heard through the City Hall rumor mill that Bryant had privately threatened to refer Blake to Marksville's chief counsel for a tax status review if he closed the clinics. He took this seriously; he knew of a handful of hospitals facing similar actions from their local governments.

When Reid tried to explain to Bryant that closing the clinics would improve Blake's financial condition, which, in turn, would lead to better quality of care for all patients, her response had been unsympathetic: "You don't measure the community's health on an income statement."

Bryant was not the only clinic supporter Reid had to reckon with. Dr. Susan Russell, Blake's director of clinics, was equally vocal about the responsibility of the hospital to the community. In a recent senior staff meeting, Reid sat stunned while Dr. Winston Lee, Blake's high-tech champion, exchanged barbs with Russell.

Lee had argued that the off-site clinics competed against the weekly in-house clinics that Blake offered under- and uninsured patients. He proposed closing the off-site clinics.

The four in-house clinics – surgery, pediatrics, gynecology, and internal medicine – cost Blake $200,000 a year in physician fees alone, Lee said. And because Medicaid was not adequately covering the costs of these services, the hospital lost about $100,000 a year from the in-house clinics. What's more, in-house clinic visits were down 10% so far this year. A choice had to be made, Lee concluded, and the reasonable choice was to eliminate the off-site clinics and bolster services within the hospital's four walls. "Instead of clinics, we should have a shuttle bus from the projects to the hospital," he proposed.

Russell's reaction had been almost violent. "Most of the clinics' patients wouldn't come to the hospital even if there was a bus running every five minutes," she snapped back. "I'm talking about pregnant teenage girls who need someone in their community they recognize and trust, not some nameless doctor in a big unfamiliar hospital."

Russell's ideas about what a hospital should be were radical, Reid thought. But, he had to admit, they did have a certain logic. She espoused an entirely new way of delivering health care that involved the mobilization of many of Blake's services. "A hospital is not a building, it's a service. And wherever the service is most needed, that is where the hospital should be," she had said.

> "A hospital is not a building, it's a service. The hospital should be where the service is most needed," Dr. Russell argued.

In Blake's case, that meant funding more neighborhood clinics, not cut-

HBR's cases are derived from the experiences of real companies and real people. As written, they are hypothetical, and the names used are fictitious.

ting back on them. Russell spoke of creating a network of neighborhood-based preventive health care centers for all of East Marksville's communities, including both the low-income housing projects and the pockets of middle-income neighborhoods. Besides improving health care, the network would act as an inpatient referral system for hospital services.

Lee had rolled his eyes at the suggestion. But Reid had not been so quick to dismiss Russell's ideas. If a clinic network could tap the paying public and generate more inpatient business, it might be worth looking into, he thought. And, besides, St. Barnabas wasn't doing anything like this.

At the end of the staff meeting, Reid asked Russell to give him some data on the performance of the clinics. He requested numbers of inpatient referrals, birth-weight data, and the number of patients seen per month by type of visit – routine, substance abuse, prenatal, pediatric, violence-related injury, HIV.

Russell's report had arrived the previous day, and Reid was flipping through the results. He had hoped it would provide some answers; instead, it only raised more questions.

The number of prenatal visits had been declining for 16 months. This was significant because prenatal care accounted for over 60% of the clinics' business. But other types of visits were holding steady. In fact, substance abusers had been coming in record numbers since the clinics began participating in the mayor's needle exchange program three months ago.

Russell placed the blame for the prenatal decline squarely on the city. "Two years ago, Marksville cut funding for prenatal outreach and advocacy programs to low-income communities. Without supplementary outreach, pregnant women are less inclined to visit the clinics," she wrote.

The birth-weight data were inconclusive. There was no difference between birth weights for clinic patients and birth weights for nonclinic patients from similar backgrounds. In fact, average birth weights in 1989 were actually lower among clinic patients. Russell had concluded that the clinic program was too new to produce meaningful improvements.

On the positive side, inpatient referrals from the clinics had risen in the last few years, but Russell's comments about the reasons for the rise were speculative at best. HIV-related illnesses and violence-related injuries were a large part of the increase but so were early detection of ailments such as cataracts and cancer. Reid made a note to ask for a follow-up study on this.

He put the report down and stared out his window. Blake had a responsibility to serve the uninsured. But it also had a responsibility to remain viable and self-sustaining. Which was the stronger force? It came down to finding the best way to provide high-quality care to the community and saving the hospital from financial difficulties. The consequences of his decision ranged from another year of status quo management to totally redefining the role of the hospital in the community. He had less than a week to decide.

What should Reid cut, and what should he keep?

Experts in health care and public service discuss his options.

Blake Memorial's long-term viability is at risk. Reid must make substantial cuts immediately, and eventually the hospital must relocate.

I see Bruce Reid making the following presentation to Blake Memorial's board of directors:

Six months ago, I came to this hospital because of the challenge it offered. Blake certainly hasn't disappointed me: it has rising costs, a healthy operating deficit, a high percentage of Medicaid low-scale reimbursement, forceful physician demands, potential physician defection, and a poor location and reputation.

In its current state, Blake's long-term viability is at risk. While we must immediately address the operating deficit, the core issue is the hospital's long-term direction. While I believe that we can solve the immediate financial crisis, the board must decide Blake's future so that an orderly planning process can begin.

I recommend eliminating 260 staff positions immediately, bringing

DAN PELLEGRINI *is a judge of the Commonwealth Court of Pennsylvania. Previously, he was city solicitor of Pittsburgh, Pennsylvania, where he negotiated a landmark settlement of Presbyterian-University Hospital's tax-exempt status. The case resulted in the hospital having to pay the city of Pittsburgh $11.4 million for ten years of municipal services.*

DRAWINGS BY CHUCK MORRIS

staffing more in line with my former hospital. I see no reason why we cannot achieve comparable quality of care at that level of staffing, assuming that effective management procedures are put in place. I am confident that our management is capable of doing this. I calculate that such personnel reductions will save close to $5.9 million, rather than the $2 million originally forecast. I do not know the net inpatient revenues that the clinics generate, so I cannot make a recommendation about closing the clinics, but if we do, I expect little opposition from the city. The appalling conditions of the city-supplied facilities and the funding reduction make me believe the city is no longer committed to the clinics.

The cuts I am suggesting will generate sufficient working capital to examine available options. But over time, serving the same patient population – with its high proportion of Medicaid patients – will eat away at the surplus generated from these personnel reductions. Because of our present location and negative image, Blake cannot hope to change its patient mix.

As I see it, the hospital has two options. One is to gradually abandon this neighborhood. Blake could open free-standing care centers in a more affluent suburb of Marksville, in conjunction with our staff doctors. At the same time, I recommend construction of a minihospital in this neighborhood, with an emergency room, an operating room to perform same-day surgery, a neonatal unit, and a sufficient number of inpatient beds to handle uncomplicated matters from the emergency room, surgical center, and obstetrics.

We could open a physicians' office near the minihospital, which eventually should generate a good profit, primarily because of higher insurance reimbursement rates that come with serving a more affluent population. Such a relocation would satisfy our admitting physicians, who would receive both higher reimbursements and the newest and best technology.

Initially, both the care centers and the minihospital would feed more serious cases to Blake's current location, helping to increase margins. But through phased expansion, the entire operation eventually would relocate to the suburban site. We could then convert the old hospital to a nursing home or other specialized center, depending on what is more advantageous from a reimbursement perspective. Blake's name would be changed to reflect our more upscale image. Quite simply, this strategy is to out-St. Barnabas St. Barnabas.

The alternative is not as dynamic, but it is one that I am obliged to put forth because you are directors of a nonprofit institution. As with other hospitals, when Blake was established as a nonprofit, it was chartered to carry out a societal need not served by either government or for-profit enterprises. We were created to serve the medical needs of the community, especially those who could not receive such care elsewhere.

If we opt to move from this neighborhood, we will be abandoning that societal mission for a more financially sound and technically advanced hospital. Instead of seeking insured reimbursements, we could look to serve our present patients' needs, knowing that in the present reimbursement climate our financial position will always be precarious.

If we decide to stay in our present location, we will need to cut costs ruthlessly and accept serviceable rather than cutting-edge technology. We will provide adequate and otherwise unavailable medical care to a section of the population that has no other options. Inevitably, this will result in the defection of a significant number of primary admitting physicians, with an attendant loss of profitability from insured patient referrals. In five to seven years, rather than celebrating the opening of a new hospital, we will, in all likelihood, be wondering how to keep the existing hospital open.

The only justification for staying put is that we are meeting a societal need for which we were created and which no one else is meeting, certainly not St. Barnabas.

If you choose the option of continuing to serve the same patient population, I will, for the good of my career, be forced to submit my resignation. I could not, with a clear conscience, remain committed to a hospital that knowingly courts financial insolvency. My peers would think of me as a social worker, not a bottom-line manager. I await your decision.

The solution lies outside Blake and in the community as a whole.

To paraphrase Sister Irene, CEO of Daughters of Charity National Health System, Bruce Reid is caught in the margin-mission trap. He imagines he has to choose between fiscal survivability of the hospital and meeting community needs. He sees only unappealing options – closing clinics, cutting staff, freezing salaries. Framed in such narrow terms, the decision is as simple as it is hopeless; Reid will no doubt make

ELLEN SCHALL *is president of the National Center for Health Education, a private nonprofit organization located in New York City. From 1983 to 1990, she was commissioner of the New York City Department of Juvenile Justice.*

the cuts. But, instead, with creative leadership and a willingness to reach out, Reid can develop a service mission that also meets the concerns of margin.

The mission will best be developed not by Reid alone but in cooperation with his staff and in conversations with the community. Reid should lead this process and authorize the contributions of others.

Reid may have a willing ally in Clara Bryant, Marksville's commissioner of health services, and he should focus on bringing her into the decision-making process. He needs to lower his guard and make use of Bryant's leverage and insight. He can use his decision not to close the clinics – at least not for now – to build cooperation and get her to help search for a long-term solution.

That solution lies outside the confines of the institution. Working in concert with the community, Reid must begin the difficult process of identifying the unmet health care needs of Marksville's underserved residents and then explore and introduce innovative solutions.

The New York City Department of Correction faced a related challenge in the early 1980s when I served as deputy commissioner. Like many correction departments across the country, New York City had enormous overcrowding problems in its jails. But narrowly defining our options – that is, by including only choices over which we had control – got us nowhere in solving the long-term problem. We searched for beds much the way Reid is searching for ways to cut costs: alone, with bad choices, inadequate information and resources, and increasing frustration.

With the problem approaching crisis proportions, we started to reach out for help. We convened monthly meetings of all the actors in the criminal justice system – the judges, prosecutors, police, the defense bar, probation, the pretrial service agencies, the mayor's office of criminal justice – most of whom had a much more direct influence on the jail population and many of whom had definite ideas about what was wrong and what needed to be done.

By involving them and getting wider ownership of the problems, we got better solutions. Judges gave priority to cases where the defendant was incarcerated, probation hired typists to speed up preparation of presentencing reports, and the police changed their booking procedures so people who had been arrested saw a judge more quickly. The changes freed up hundreds of jail beds.

My experience with solving the problems of jail overcrowding involved only the public sector. In health care, as in many other fields, the reach needs to be broader. Reid needs to include both the public and the private sectors in his coalition: not just the hospital and city hall but the business community, social advocacy agencies, community-based self-help organizations, and the medical community. He must charge the group with creating solutions that go beyond the routine – new ways of solving old problems.

The Marksville coalition does not need to begin from ground zero. Many communities have struggled with similar problems and have found innovative solutions. Reid needs to call on all the networks of his coalition members to make sure his group begins with a good understanding of what has been tried already. He could also take advantage of groups such as the National Civic League, which maintains an index by subject matter of local solutions to pressing urban problems, or the Ford Foundation-Kennedy School of Government Innovations Award program, a repository of innovative approaches to pressing state and local concerns. Two interesting models come to mind.

☐ In Montgomery County, Maryland, the local health department and the local medical society formed a partnership to treat high-risk indigent women patients who were spurned by local hospitals due in part to the high cost of obstetric malpractice insurance. Three of the four hospitals had stopped providing obstetrical care to these patients. With both the health department and the medical society pushing, all four agreed

to an equitable patient distribution plan, and private obstetricians agreed to serve as part-time health department employees during labor and delivery. The doctors are paid by the county and covered by the county's self-insurance program.

☐ In Fairfax County, Virginia, the Medical Care for Children Project tackled a significant unmet need: before 1986, there was no comprehensive and consistent countywide medical or dental care available for children of the working poor. The project persuaded private medical providers – HMOs, physicians and dentists, pharmacies and laboratories – to provide services at 50% of actual cost or less. Business leaders were invited to contribute funds, and the county paid administrative costs and subsidized the cost of care.

There is no easy blueprint to offer Reid, but there are workable alternatives. Changing the way a community defines and meets its health care problems is tough and complicated work that requires imagination and encourages creativity and persistence. Reid will ultimately have to chart his own course, but he will be more likely to succeed if he reaches out beyond the four walls of Blake Memorial.

Reid needs a market-niche strategy if he expects to turn the clinics around and eventually expand them.

I know what Bruce Reid is up against. After trying for over a year to turn around an evening clinic in a low-income community, I was forced to replace it with a bus service to the hospital a few miles away. Under the circumstances, closing the clinic seemed to be the only rational solution. In retrospect, however, it was less than optimal. I know now that Bruce Reid has other options that he should pursue. On all fronts – political, social, and economical – an expanded network of clinics is Blake's best long-term strategy.

KEITH F. SAFIAN *is president and CEO of Phelps Memorial Hospital Center, a 215-bed acute care hospital in North Tarrytown, New York. A fellow of the American College of Healthcare Executives, he has worked as an administrator in voluntary and public hospitals for the past 18 years.*

First, closing a clinic is a serious blow to the community it serves. When I closed the evening clinic and provided bus service in its place, I was surprised to see patient visits fall off so precipitously, especially among adult males. Some patients went to a local daytime clinic run by the county, but many others simply opted not to seek early treatment for health problems.

While the closure of my clinic was painful, it was not a public relations disaster for the hospital. From the outset, the county government was aware of the financial problems we faced and participated in developing the interim solution. When it became clear that the clinic would always lose money, government participants helped make the final decision to close the clinic. Consequently, negative publicity was deflected from the hospital.

Unfortunately, the financial benefits were modest. The clinic was losing $50,000 a year, but the eventual savings amounted to only $15,000. As it turned out, $35,000 of the loss was overhead that had to be redistributed to other cost centers.

Reid can learn from this. First, he should not underestimate the value of cultivating a strong relationship with local government. His current relationship with Bryant is neither supportive nor trusting. He should address this immediately. Even though Blake is financially responsible for the clinics, Reid should work toward establishing a partnership with Marksville City Hall in general and with Clara Bryant in particular. He should open the clinics' books for public scrutiny and let Bryant participate in long-term planning to restructure the clinics.

On the social front, Reid needs to accept that the clinics are necessary for the reasons Dr. Susan Russell gives. The shuttle bus service that Dr. Winston Lee suggests could never serve the community in the same way. Neighborhood clinics provide an important social function as well as a medical need, especially in low-income communities. They give residents a sense of ownership and self-determination that they cannot find in a large hospital-based clinic. At a local clinic I was involved with, the indigent community sponsored a successful fund-raising event.

Economically, it is possible for Reid to turn the clinics around so they continue to generate crucial inpatient referrals and still run efficiently. He needs to think in terms of a market-niche strategy because Blake will never be in a position to compete head-to-head with St. Barnabas. It makes sense to think in terms of extending the reach of the clinics to include low- and middle-income communities in other Marksville neighborhoods, as well as in the surrounding suburban and rural areas. This reach would give Blake the coverage it needs for more inpatient referrals and give it a near monopoly on the services it can operate economically.

Blake Memorial – and Blake Memorial alone – is responsible for serving the health care needs of East

Marksville's low-income community in the absence of a publicly funded city or county hospital. If Reid closes the clinics, the city would be justified in canceling Blake's grants and other support.

Reid's best bet is to deal with the immediate financial problems through belt tightening – balancing staffing and patient volumes – while concurrently developing a longer term plan to expand the clinic system and make it more cost-effective.

He needs to take decisive action now to ensure that the clinics become revenue generators for Blake as quickly as possible. First, he should evaluate the clinics' productivity. He should limit clinic hours by consolidating sessions and by cutting staff positions accordingly. Other short-term measures can be taken: centralize record keeping, assist more patients to enroll in Medicaid, increase charges to sliding-fee patients, add clinics staffed with social workers or other lower cost providers, and phase out one or two clinics that lose too much money.

Reid's dilemma is fundamentally about balancing short-term financial constraints against long-term strategic goals. It is a problem faced by virtually all hospital administrators in this era of cost containment. Without imaginative and bold leadership, however, the outcomes will be stopgap at best.

By publicly committing himself to creating a clinic network as the centerpiece of a long-term strategy to rejuvenate Blake Memorial, Reid will satisfy the board of directors, the city government, and the community.

Instead of playing with figures and becoming pessimistic, Reid should take charge. He must frame an effective strategy that treats the clinics as a resource, not a cost.

JANE DELGADO *is CEO of the National Coalition of Hispanic Health and Human Services Organizations in Washington, D.C.*

Bruce Reid must act swiftly and decisively to define the goals of Blake Memorial. He has already spent too many months playing with figures and becoming pessimistic, rather than taking charge and reframing the hospital's long-term strategy. He has to rethink the framework on which the hospital operates. His challenge is to develop a new understanding of whom the hospital will serve, change how the clinics operate without incurring unreasonable costs, and develop more tailored analyses of the hospital's operation.

Whom the hospital will serve. As it stands, Blake serves only the east side of Marksville, comprised primarily of low-income residents. St. Barnabas, on the west side of the city, serves the more affluent communities. Reid's primary objective must be to broaden the hospital's base to include more paying patients, while continuing to serve the local low-income communities adequately. To do so, he must redefine the hospital's niche and rethink the competitive relationship between Blake and St. Barnabas.

Fundamentally, Blake cannot and should not try to compete with St. Barnabas as they differ in both market and mission. Reid should break out of a narrow comparative analysis and attempt to assess Blake's mission *independently*. He can then more precisely determine the community's needs and create the appropriate services for satisfying those needs.

How the clinics should operate. The clinics play a crucial role in developing Blake's mission. Reid must embrace Dr. Susan Russell's prescription for creating locally based preventive health care centers for the entire Marksville metropolitan area, regardless of income or geographic location. Such a network would be both politically correct and financially lucrative. A clinic network would provide a different approach to delivering care: Blake would provide "high-touch" health care, while St. Barnabas would focus on "high-tech" care. Financially, a more extensive clinic system would enable Blake to expand its patient base, increase revenues, and reduce its losses.

A careful analysis would quickly reveal that the clinic system as it is run now is both mismanaged and underutilized. To correct this, Reid needs to think of the clinics as an extension of the hospital, rather than as an optional appendage. This calls for positioning them as part of a cooperative system rather than as a peripheral cost center that drains resources.

The clinics must become the point of entry into the Blake system. Once patients – both paying and nonpaying – have entered the clinic system, Blake benefits by providing many of the routine follow-up services either at the clinics or within the four walls of the hospital. For those services involving high-technology diagnostics or treatment, the patient would be referred to St. Barnabas.

An important first step in implementing the new strategy is to renovate the existing clinics. Above all,

this is an opportunity for Reid to build relationships with local community and political groups and to ensure community ownership of the clinics.

Developing analyses for operation. Of course, none of this is possible unless Reid rethinks his role as administrator. He must recognize that he is no longer at a university-based hospital where research takes precedence over service. Improving the "quality of service" at Blake is central to his mission and goes far beyond counting beds and comparing numbers of employees. Reid needs to look beyond gross figures and identify the types of patients Blake serves and the types of employees necessary to satisfy those needs.

Reid must analyze the cost and revenue of the different categories of health professionals and services at Blake. The megacomparisons on which he previously relied will not give him enough information. Moreover, in the analyses of potential cuts, he must try to project future trends in both client population and reimbursement strategies.

At the same time, Reid must avoid the use of across-the-board cuts as they are unfair and generally seen as a sign of weakness. Decisions must be based on the actual care that's needed. For example, it may be inequitable to cut 2% from a department that has three physicians and 2% from a department that has 20 physicians.

Finally, Reid must be prepared for the inevitable loss of staff that occurs when there is a change in how an organization conducts business. Some will welcome the new relationship with the community, others will be appalled. The work will be in discerning staff allegiances and building an agenda for those who remain. I suspect that Winston Lee, the chief of surgery, would be one of the first to leave Blake.

The financial viability of the hospital depends on Reid's ability to make fundamental changes in the institution's mission. Those members of staff who cannot accept these changes will have no choice but to leave. In the long run, this will be best for Blake Memorial and for the community it serves.

Reid cannot and should not solve all of Marksville's social and health needs. His job is to run an economically healthy hospital.

Bruce Reid should close the clinics. He doesn't have to apologize for doing his job. He wasn't hired – nor does the hospital have the available resources – to solve all Marksville's social and health needs. Blake Memorial's mission in the community is to provide acute inpatient and some outpatient care within its four walls, and it can only succeed in this role if it is economically healthy.

It may sound callous, but Reid would be doing the community a service by closing the off-site clinics. If nothing else, such a bold move would bring the issue to a head and mobilize Marksville's political and community leaders to search for an alternative solution – one owned and operated by the public sector.

Above all, Reid must lead Blake by defining a clear role for the hospital. While an off-site clinic system is a noble pursuit, it must be discontinued because of poor financial return. Unlike the 1980s, when it was fashionable and financially feasible for hospitals to assume an interest in and responsibility for a broad range of community, social, and health needs, the 1990s call for a leaner approach. Instead of offering nonrevenue-generating services, private hospitals like Blake should return to the basics of serving specific acute health care needs.

Reid should argue that it is a mistake to make Blake the hub for the coordination, provision, and financing of the community's social and health needs. In the era of inadequate Medicaid coverage for the uninsured, such a business philosophy by a private hospital is an inappropriate use of resources. Clearly defined agencies established by the city, state, and federal governments have these responsibilities.

Reid should fight for the best in-house acute care services he can afford, in line with what is appropriate for the community's needs. For example, if demographic projections indicate that the child population in East Marksville will grow over the next few years, then upgrading Blake's neonatal wing would be appropriate. At the same time, Reid needs to evaluate other internal services with an eye to eliminating as much waste as possible. If, for instance, a patient stays in the hospital over the weekend because the physical therapy department is closed, then something must be done to reform the way those services are delivered, possibly keeping a physical therapist on call on Saturdays and Sundays, for example.

Of course, Reid should play a pivotal role in leading the transition to a publicly run clinic system. His first step is to convene a meeting with Clara Bryant, Marksville's commissioner of health services, and Richard

BERNARD LACHNER *is vice chairman and CEO of the Evanston Hospital Corporation, which operates privately run acute care facilities in Evanston and Glenville, Illinois.*

Tuttle, CEO of St. Barnabas Hospital. If Tuttle is unwilling to meet with Reid, he should make sure that another member of St. Barnabas's administration or board of directors is present – preferably someone more sympathetic to the needs of low-income neighborhoods. Ideally, the meeting would lay the groundwork for transferring responsibility for the clinics from Blake to the city government. Reid should make it clear that Blake would relinquish control of the clinics and both Blake and St. Barnabas would participate in planning them. Both hospitals should be involved because both will draw on the clinics for their patient referrals. Also, it is only right that such an important public health care service receives input from all parties.

Blake's present financial problem typifies the bankrupt policies of government at all levels. For the last decade, the federal government has passed the cost of health care along to the states, which passed it along to the cities, which, in turn, passed it along to the hospitals and the communities they serve. In addition, the cost shifting has raised the expense of health care to the insured – both businesses and individuals – which now must pay for the uninsured.

As a consequence, hospital emergency rooms and outpatient clinics have become the repositories for a variety of underfunded and ill-fated government programs. The stress on the system is exacerbated by the needs of uninsured mental health patients released from facilities and an increasing number of homeless people, all victims of poverty, poor education, and crime.

Reid is in a position to turn the tide on the buck passing and put the responsibility back on the government's shoulders. It will take courage and strong leadership to fashion a response, but maybe this time a more equitable and humane solution to the health care needs of communities like Marksville can be devised.

Reprint 91506