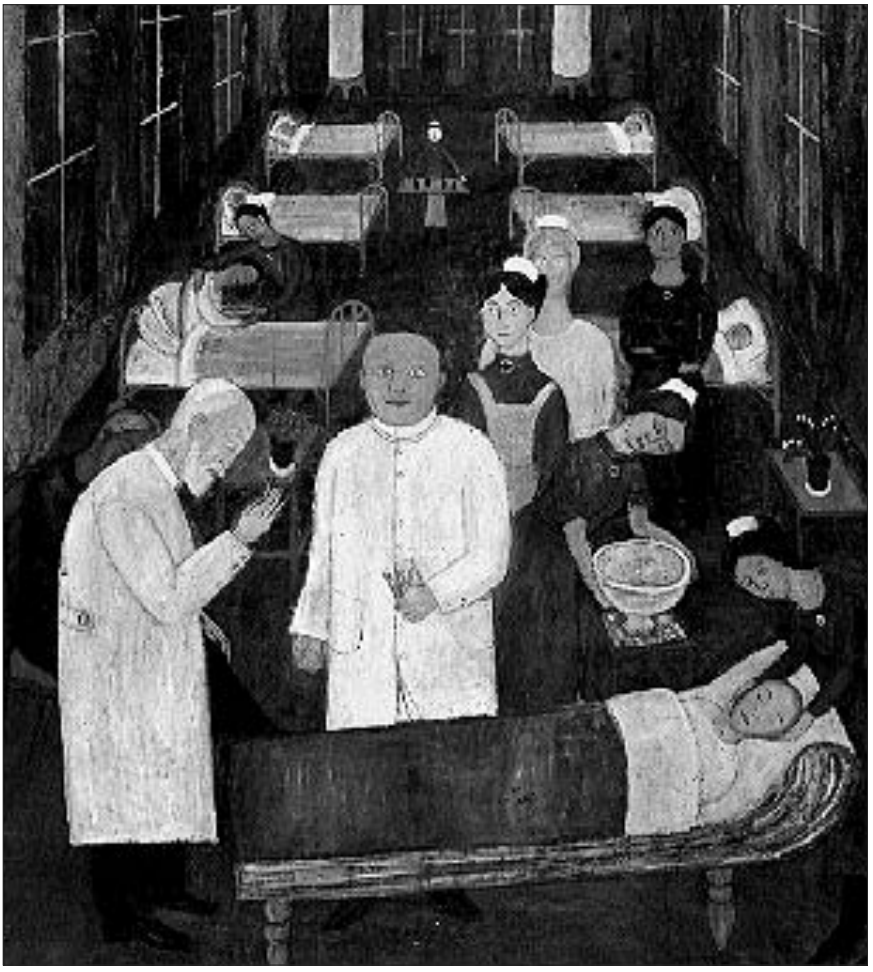
The Future of The Hospital

by C. Everett Koop

Back in medical school, when my eyes would become tired and sore late at night after hours of peering through a microscope, I would often take a break by walking to the middle of the Queensboro Bridge, where I would gaze into the distance at the lights of Manhattan or at the stars overhead. Looking far away was a welcome change, and it also gave me a better perspective on my work.

In more recent years, since leaving my post as surgeon general in 1989, I have devoted myself to the challenge of health-care reform. Traveling throughout the United States, I have spoken out on the ethical imperative of reform



Hospital Ward II *(1920), by Hilding Linnqvist*

and offered concrete suggestions about what we need to do. It has been a formidable task, often requiring intensive, almost microscopic examination of the many problems within the American health-care system. Thus, the opportunity to look into the distance, into the future, to try to get a glimpse of what the American hospital might look like 10 or 20 years from now, comes as another welcome change. Yet the images I see are more kaleidoscopic than telescopic: intriguing but always shifting, often reflecting the past as much as projecting into the future.

The hospital has become one of the dominant institutions in American society. The hospital is the one building in the community that each citizen will enter sooner or later. As the 20th century has seen the medicalization of the milestones of life—birth, pain, aging, death—the hospital has become one of the few remaining centers of communal life in our individualistic society. In popular imagery and in the top television shows, the hospital has replaced the Wild West, the city streets, and the courtroom as the place of ultimate human drama. *Gunsmoke*, *Hill Street Blues*, and *L.A. Law* have given way to *ER* and *Chicago Hope*. And for years, *General Hospital* ruled daytime television, a pop-culture icon demonstrating not only the preeminence of the hospital in American society, but also the "generalization" of the hospital—its evolution into an institution that provides all medical services to all people. We have become so accustomed to this image of the hospital that we may forget how recently it developed. And we may find more hints about the future of the hospital in its past than in its present.

The general hospital of the late 20th century is the product of a variety of very different ancestors, and it will give birth to a variety of very different descendants. Before the modern era, American hospitals served a number of distinct and differing functions, often on the periphery of both medicine and society. From their 17th-century origins as almshouses and pesthouses, American hospitals only gradually became associated with medical care. During the 19th century they branched out in different directions, as some became institutions devoted to the treatment of a particular affliction (tuberculosis, blindness), a religious or ethnic group (Catholics, Protestants, Jews), a segregated racial group (African Americans), or an age group (children).

Even in the 19th century, most Americans did all they could to avoid hospitals, which were stigmatized as places for the indigent and the dying. For a while, progress in 19th-century home medicine and home surgery even led medical visionaries to anticipate, as the author of a prize-winning Harvard University essay put it in 1876, "that state of perfection where hospitals can be dispensed with." Instead, of course, the hospital grew in importance, as the rise of scientific and technological medicine in the early 20th century led to the hospitalization of medicine and to the medicalization of the hospital. But the 21st century may see a renewed diversification, or even fragmentation, of the American hospital.

Since the early 1980s, cost-control measures have drastically changed the hospital's economic environment from one in which it thrived to one in which it must struggle even to survive. Urban hospitals dependent upon city and state taxpayer subsidies, Medicare, and Medicaid will be forced to retrench, requir-

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ing them to reduce beds and lay off personnel. Academic medical centers may see support for graduate medical education dwindle as a result of inevitable reductions in the growth of Medicare and in a diminished flow of federal funds for research. Meanwhile, curricular changes in medical education may put more students in ambulatory care centers and fewer in traditional hospitals. Suburban and rural hospitals, often competing with one another for the opportunity to provide increasingly costly care to a shrinking patient pool, will be forced to merge or shut down.

Managed care, growing far more rapidly than either its proponents hoped or its detractors feared, will put even more pressure on American hospitals. Some will simply be bought out or squeezed out of the market by hospitals owned by health maintenance organizations (HMOs). Others will find that their financial agreements with managed-care organizations force them to carry even more of the financial risk of patient care. The untoward aspects of managed care, especially of investor-driven, for-profit HMOs, may be addressed in time, either by state-by-state legislative mandates or by businesses and citizens as they gradually realize that shortcut, short-term-profit medicine may be unprofitable in the long run. But these antidotes to the problems of managed care may take years to assert themselves, and in the meantime hospitals face some tough sledding.

The solutions to these problems may lie in a return to the kind of diversification among hospitals that was seen in the past, as the harshness of the new economic climate forces hospitals to realize that they cannot be all things to all people. Competing hospitals may need to divide specialty coverage, with only one hospital in a city performing coronary bypass surgery, for example, while the other handles all magnetic resonance imaging. As economic concerns and surgical advances lead to more same-day surgery, allowing patients to return home from the hospital without an overnight stay, hospitals may need to support freestanding ambulatory clinics or same-day-surgery centers in several neighborhoods, and to extend their work in medical education to these sites.

But while some functions formerly performed in the hospital may need to be conducted at new locations outside the hospital, other services can be drawn into the hospital. A number of hard-pressed rural hospitals have found that their empty beds can be filled with long-term custodial care patients. The long-term care crisis is but one of many health-care issues our society needs to resolve. A year in a nursing home now costs more than a year at Princeton. The economic and institutional solution of the long-term care problem may need to await the retirement of millions of baby boomers (now turning 50 at the rate of one every 7.6 seconds), but hospitals should be poised to provide their part of the answer. And we also may see a return to disease-specific or condition-specific hospitals, as more Americans live longer with chronic ailments.

There is one final and vitally important way in which hospitals in the early 21st century may find themselves back where they started, for part of their function must remain the free care of those in need. I pray that charity grows, not diminishes, in the America of the 21st century, and that society as a whole provides hospitals support so they will always be able to care for those in particular need. We cannot let the hospital's present or future mission for curing eclipse its historic mission for caring.