Founded in Cleveland
At the city’s Colonial Hotel in September 1899, eight hospital superintendents from Michigan, Ohio, and Pennsylvania met to launch a national association for exchanging ideas. Seven years later, it was renamed the American Hospital Association.

Health Care for All
As early as 1907, racial discrimination made the agenda. Records emphasize that the AHA was founded to promote better hospital care for all people. Members have affirmed this position many times, notably in a 1970 statement on health care for the disadvantaged.

Emblem Trouble
This insignia, now part of the AHA seal, became official in 1927 after an earlier proposal failed to fly. “Very beautiful effects can be produced by embroidering this insignia,” gushed the Bulletin of the AHA.

A CENTURY OF THE

ARTICLE BY
Michael Lesparre, former director of the Division of Communications in the AHA’s Washington office, with contributions from Gail Lovinger and Kathy Poole, Office of the Secretary, and the AHA Resource Center.

MADE POSSIBLE IN PART BY EDUCATIONAL GRANTS FROM:
World War I
The association took some of its first steps into public policy during "the war to end all wars." In 1917, it convened a war service committee for hospitals. The AHA urged hospitals and the government to work together in caring for soldiers and attending to the public's welfare.

Covering the Field
After running meeting agendas and notices in the National Hospital Record and elsewhere for many years, the association entered the publishing field in the 1920s, first producing the Bulletin of the AHA (shown here in 1928). Hospitals, a twice-monthly magazine, made its debut in 1936. With an expanded scope and audience, it was renamed Hospitals & Health Networks in 1993.

recking crews long ago demolished Cleveland's Colonial Hotel, where eight hospital administrators met in 1899 to found the Association of Hospital Superintendents of the United States and Canada. The group's name has vanished, too—just seven years later, it became the American Hospital Association. But the AHA's mission has stayed the same for 100 years. Today's aim to improve the health of individuals and communities harks back to early missions that spoke about "promoting the welfare of the people."

At the first meeting, the objective was to talk shop about management, economics, hospital inspections, and operating plans. But the founders soon realized they couldn't get far without acknowledging a far more basic interest. "The hospital is an institution in which the patient comes first," declared Cincinnati Hospital chief John Fehrenbacht, AHA president in 1903. "His interests and welfare are paramount."

Membership grew to 234 within eight years. Standards and skill-building were top concerns, but policy questions were there from the start, too. Along with dispensary abuse, housekeeping, and relationships between administrators and nursing supervisors, early meetings focused on care for the poor and indigent. Even hospital food made the agenda. As for professional standards, the association recommended university training in hospital administration for chief executives. To deepen the management ranks, the AHA's 1906 convention voted to admit associate members—those next in line of authority below the superintendent. By 1913, AHA membership included trustees, medical staffs, and superintendents of nursing. Five years later it established institutional membership, and by the time the AHA turned 27, it had 734 members.

As the founders hinted, the link between hospitals and their communities has been strong all along. As early as 1907, records emphasized that the AHA was established to promote better hospital care for all people—and the issue of racial discrimination was on the table. Accountability to the public was considered an official principle of service and fiscal responsibility in 1909. Yet, in some ways, the young organization was very insular. In discussing a paper on hospitals and the political scene, for example, members concluded "that politics and hospitals should not be related at all."

Publications weren't as complex at the turn of the century as they are today, but they paralleled the association's development and are a critical part of its history. Magazines and journals carried meeting announcements and agendas, and as hospital management issues began to gel, journal sections were devoted to hospital departments and operations. The AHA used The National Hospital Record, which eventually became the independent Modern Hospital, as its first official organ. Del Sutton, publisher of the Record, was invited to the first meeting as an observer. In the mid-1930s, the AHA began publishing its own magazine, Hospitals, which later evolved into today's Hospitals & Health Networks, and joined the Internet revolution with its home page in 1996.

As the United States entered World War I, the AHA began to get involved in public policy. In 1917, it unanimously passed a resolution to set up a war service committee for hospitals and urged cooperation between hos-
Research Hub
After the war, the Hospital Library and Service Bureau opened and was later acquired by the AHA. Now known as the AHA Resource Center, it houses the Center for Hospital and Healthcare Administration History and the National Information Center for Health Services Administration.

Library Pioneer
The AHA's library was originally named for Asa S. Bacon, its treasurer for 34 years, chairman in 1923, and first head of the standing library committee.

Justus Ford Kimball
He set up the first hospital prepaid payment plan in Dallas, the prototype for Blue Cross plans. An AHA award for health care financing and delivery honors him.

C. Rufus Rorem
An advocate of prepaid coverage, he joined the staff in 1929. The AHA later created the Hospital Service Plan Commission, which became Blue Cross & Blue Shield.

Hospitals and the government in the care of soldiers and the "health of our people." In the early 1920s, the AHA began working with other national groups to set standards for hospitals and medical education, cooperating with the American College of Surgeons and the American Medical Association. Eventually that cooperation led the groups to set up the Joint Commission on Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organizations, in 1952.

During the postwar years, the Hospital Library and Service Bureau opened at the AHA, though it was initially run by a separate group. The AHA acquired the bureau in 1929. The AHA library and its services to members and other organizations grew rapidly during the next several decades. The library was named for Asa S. Bacon, who had been AHA treasurer for 34 years, president in 1923, and the first chairman of the standing library committee. Now known as the AHA Resource Center, the library houses the Center for Hospital and Healthcare Administration History and the National Information Center for Health Services Administration, created in 1997 by the AHA, the American College of Healthcare Executives, the American College of Physician Executives, and the Healthcare Financial Management Association.

The AHA was an early supporter of health insurance, which made its first appearances in the late 1920s. Justin Ford Kimball had recently organized the first hospital prepayment plan for Dallas teachers in 1929, when the AHA hired C. Rufus Rorem, Ph.D., a nationally recognized proponent of prepaid coverage, as its expert on group hospital insurance. With the support of his colleague, John R. Mannix, assistant director of the University Hospitals of Cleveland, Rorem was largely responsible for Blue Cross insurance as a national movement.

By 1937, the AHA had organized the Hospital Service Plan Commission, which adopted a generic blue cross for its logo and later became Blue Cross and Blue Shield. The AHA also opened associate membership to not-for-profit prepayment plans. Within a year, 40 Blue Cross plans had signed up.

As the AHA became more sensitive to the relationship between the federal government and hospitals, it joined with the Catholic and Protestant hospital associations in 1937 to form a joint advisory committee to consider federal legislation and represent the concerns of the field to Congress. Since then, the AHA's advocacy efforts have always emphasized collaboration.

As the association took a greater role on the national scene in the 1930s, big changes occurred internally. It moved out of the space it had shared with Modern Hospital and bought a permanent headquarters building at 18 East Division in Chicago. Members founded the House of Delegates to promote a democratic process and formed councils to set standards and create common ground for an increasingly diverse membership. The first councils looked at administrative practice, professional practice, hospital planning and plant operation, public education, government regulations, and association development. AHA members and staff began setting guidelines for working with local governments and insurers. They developed manuals for hospital pharmacies, contracts with doctors, and job descriptions.

Institutional membership became the primary way to belong to the AHA, though personal membership continued. In 1938, the mission underwent a revision: "Its object shall be to promote the welfare of the people through the development of hospital and outpatient services." At the AHA's urging, state and local hospital associations also began to emerge. The Ohio Hospital Association had already opened its doors in 1920 and agreed to collect dues on behalf of the AHA from its constituent members. Soon after, groups formed in Wisconsin, Michigan, and other states.

The association's sharper focus on institutional issues also raised the stakes for chief executives. In 1932, AHA president Paul H. Festler, superintendent of Wesley (now Northwestern) Memorial Hospital in Chicago, called for a college of hospital administration modeled after the American College of Surgeons. Within a year, Festler and others drew up plans for the independent American College of Hospital Administrators and in 1934 presented them to the AHA Board of Trustees. Though the relationship between the two groups would be close, the "AHA could not, by virtue of its own constituency, show any distinction of standards of con-
petency for hospital administrators," the documents stated.

Also in the 1930s, the AHA created awards for leadership and achievements in hospital administration and community service, presenting its first Award of Merit to Matthew O. Foley, editor of *Hospital Management* magazine, in 1934. The 1939 recipient was Malcolm T. MacEachern, M.D., who organized the hospital standards program of the American College of Surgeons. In 1955, the Award of Merit was renamed the Distinguished Service Award.

The New Deal forever changed perceptions about the federal government’s influence on hospitals. With members already reeling from bad debt and renovation needs that languished during the Great Depression, the AHA expanded its advocacy role, joining with the Catholic and Protestant hospital associations to oppose a crush of federal rules and to stress the need for local control over health care. In 1943, recognizing the demands of the AHA’s work in the national arena, the board quadrupled membership dues for hospitals—over the protests of AHA CEO Bert Caldwell, who worried that members could not afford the hike. The AHA published its first *Listing of Hospitals* in 1945, which continues today as the AHA Guide to the Health Care Field.

During World War II, the AHA also opened the Wartime Services Bureau to see that members had adequate supplies during shortages and rationing. The AHA urged the government to use civilian hospitals for its needs. It also supported the Cadet Nurse Corps in 1943, as thousands of doctors, nurses, dietitians, and other professionals joined the armed forces. The AHA Washington Bureau helped implement the Lanham Act of 1941, which brought federal aid to defense areas, including assistance to nonfederal hospitals. And it teamed up with the U.S. Public Health Service and national nursing groups in urging young women to enter nursing careers.

When the war ended, the association needed little convincing about opening a permanent office in the nation’s capital. The wartime bureau was renamed the Washington Service Bureau and was soon steepled in national health policy. Under the leadership of George Bugbee, who succeeded Caldwell as CEO, the AHA helped draft the Hill-Burton Hospital Survey and Construction Act of 1946. Its implementation continued until 1975, and the law remains one of the most significant national events in health care. In the years leading up to Hill-Burton, the AHA’s Commission on Hospital Care carried out a national survey that was, in great part, the impetus for the law. Over its 30-year span, Hill-Burton distributed $4 billion to 6,900 hospitals, skilled nursing facilities, nursing homes, and other facilities.

The AHA also supported the National Health Service bill to help the medically indigent, promote health insurance, and extend Social Security benefits to employees of not-for-profit groups. But the association joined other health care groups in opposing mandatory national health insurance, a campaign led by Sen. Robert Wagner of New York. Under pressure from health care associations and others, the Wagner-Murray-Dingell bill fell to defeat. In 1947, the AHA became embroiled in disagreements over a plan by the Veterans Administration to open facilities with more than 150,000 hospital beds. The AHA wanted the government to work with private hospitals to care for veterans, but politics dictated otherwise.

Rising costs and access to care increasingly appeared on the radar screen in the 1940s, leading to calls for voluntary health insurance. During Bugbee’s tenure as CEO, the AHA created the Blue Cross Commission and the Council on Prepayment Plans and Hospital Reimbursement. By 1948, the Blue Cross Commission and the AHA’s new council promoted a single package of hospital and medical benefits, along with nationwide coverage for large employers.

Bugbee saw three principal functions for the AHA: standards and research, education, and advocacy. “They so feather together than you can hardly tell which is which,” he told his successor, Edwin L. Crosby, M.D., in a 1959 conversation. Bugbee thrived on hospital management—his goal was a bookshelf of manuals serving as essential references for hospital administrators. He and his staff went a long way toward
filing the shelf, publishing a series of manuals on such topics as admitting practices, managing insurance claims, purchasing supplies, and the use of radioisotopes.

Also in the 1940s, the AHA formed an educational trust to accept tax-deductible gifts and grants for research and education aimed at improving hospital care. The Commission on Hospital Care and its nationwide survey was the trust’s first project. This arm of the AHA was later renamed the Hospital Research and Educational Trust, and more recently the Health Research and Educational Trust.

With support from the Kellogg Foundation, the AHA and the trust created the Commission on Financing of Hospital Care, which focused much of its agenda on the health care problems of the elderly. The commission was headed by Arthur C. Bachmeyer, M.D., a hospital administrator and University of Chicago professor who had served as AHA president in 1926. Its findings, released during the Eisenhower administration, helped build momentum for Medicare.

Interest in better patient care led to a string of initiatives and commissions during the 1940s and ’50s. These activities raised the AHA’s profile and increased its influence on national health policy. The association teamed up with the AMA, the American Nurses Association, the National League for Nursing, the American Public Health Association, and the American Public Welfare Association to raise professional and institutional standards and improve care for the chronically ill. The AHA also became a key participant in the Joint Council to Improve the Health Care of the Aged, another group laying the groundwork for Medicare.

Growth and change also continued inside the AHA. To include governing boards more formally in the policy structure, the association founded a section for hospital trustees and began publishing Trustee, a monthly magazine. The AHA also urged greater involvement of women in health care, supported volunteers in hospitals, and organized its own Committee on Women’s Hospital Auxiliaries, which ultimately evolved into the Committee on Volunteers. It entered the 1950s with a new mission: “To promote the public welfare through the development of better hospital care for all the people.”

Times change, but some themes play out again and again. When Edwin Crosby became the AHA’s top executive in 1954, Capitol Hill was assailing hospitals for rising costs and spiraling services. Crosby contended that the field was being attacked unfairly by politicians and government officials. “No institution in the United States has received more challenges to change than has the hospital,” he told the AHA House of Delegates. “Buffeted from all sides, hospitals are asked to provide the most costly of treatment facilities and then are criticized for the expense of treatment.”

Like Bugbee, Crosby was uncomfortable with Washington politics and avoided the confrontations typical of congressional hearings on Capitol Hill. He appointed his deputy director, Kenneth Williamson, to head the new Washington office. Among his duties, Williamson represented the interests of hospitals on 26 provisions of the Medicare and Medicaid statute. When he left after 18 years, he was succeeded by Leo J. Gehrig, M.D., a retired official of the U.S. Navy and Public Health Service.

Not long after Crosby arrived, the AHA staff outgrew its Chicago headquarters on Division Street. In 1957 the House of Delegates authorized a four-year, 100 percent dues surcharge to finance a new building at 840 North Lake Shore Drive. Chicago Mayor Richard J. Daley was among the groundbreakers in January 1959.

Ten years later, the association added a west building, with a connecting link to its existing home. Tenants included the American College of Hospital Administrators, the American Protestant Hospital Association, and the Blue Cross Association.

The scope of AHA activities broadened again in the 1960s. Leaps in diagnosis and treatment included kidney and heart transplants and the proliferation of intensive care units. From the mid-1950s to the mid-’60s, the number of hospital employees doubled nationally. Social and political reform led to the Civil Rights Act of 1964, the enactment of Medicare, and other pieces of President Lyndon Johnson’s Great Society.
Everybody's War
Even laundry equipment makers were among health care suppliers pressed into wartime service, as seen in this 1944 ad from Hospitals. The AHA's Wartime Services Bureau helped distribute federal aid to hospitals in defense areas and made sure that shortages and rationing didn't deprive hospitals of critical supplies.

Managed Care Is Born
Industrialist Henry Kaiser (left) and Sidney Garfield, M.D., attend the dedication of Kaiser Permanente's Oakland Hospital in 1942. Kaiser founded the HMO giant the same year, inspired in part by Garfield's work in developing health services for migrant construction crews in the West.

At the AHA, staff experts in virtually every area of hospital management worked with member committees, issued advisories, and answered phone calls and letters from anyone working or volunteering at member hospitals. George Bugbee's dream for the AHA came true—and then some. Its staff and councils produced dozens of manuals, monographs, periodicals, and issue papers on insurance, staffing, areawide planning, health care data, community relations, disaster preparedness, and other issues of the day. The AHA also kept up its role in setting standards for the field. In 1963, it joined the American Association of Medical Record Librarians in recommending use of the International Classification of Diseases as a coding system.

AHA membership expanded again, bringing Blue Cross plans, hospital schools of nursing, and areawide planning agencies to the rolls. The association reorganized personal membership in 1962, setting up societies to improve the skills of hospital managers. The American Society for Hospital Engineering was the first personal membership group.

On the national front, the AHA supported Medicare in principle, but with some reservations. Fewer than half of elderly Americans had health insurance when Medicare came on the scene. The needy aged "should be eligible for an insurance basis for free health services," an AHA official statement said. "The program should afford assistance to as many of the aged as practicable, without regard to their individual financial resources in purchasing health insurance on a reasonable contributory basis."

Largely in response to Medicare and other federal changes, the AHA took a hard look at its own programs and services. A committee chaired by John H. Knowles, M.D., director of Massachusetts General Hospital, made more than 50 recommendations, including a broader base of financing. The committee suggested a separate study of the interlocking board relationship with the Blue Cross Association, a move that eventually led to dissolving that arrangement. "It was necessary for them to separate, not because they were too close, but because their relationship was perceived that way," said prepayment expert Robert Sigmond.

Thanks to Medicare, commercial insurance, and hundreds of federal and state regulations, the field had grown complex and diverse. Needing to better organize grassroots policy and advocacy work, the AHA turned to state and metropolitan hospital associations to create the Partnership for Action in 1968. Largely under the leadership of Washington office chief Leo Gehrig, the partnership gave the AHA the ability to act on legislative proposals and policy matters. It also set up nine geographic boards to enhance policy deliberations. The Regional Advisory Boards—which consisted of members of the House of Delegates and executives from the state and metropolitan associations—began meeting regularly.

Two years later, the AHA strengthened its grassroots emphasis when it held the first annual membership meeting in Washington to create a policy forum and organize lobbying for executives from hospitals and state and metropolitan associations. The attendance list has always included congressional leaders with a stake in health care legislation, federal health officials, health care leaders, and journalists. Presidents Nixon and Clinton have addressed the meeting; during the 1984 session, AHA officials met with President Reagan at the White House.

Near the end of the 1960s, the AHA took its boldest steps yet into health policy. The Special Committee on the Provision of Health Services, popularly known as the Perloff Committee, called for Ameriplan, a restructuring of delivery and financing "to make health care more accessible, more comprehensive, more responsive, and more relevant to the needs of the community." Along with chairman Earl Perloff, board chairman of the Albert Einstein Medical Center and Philadelphia General Hospital, the 15-member group included three doctors, two health lawyers, a member of the clergy, and six hospital administrators. Alex McMahon, the association's president from 1972 to 1986, still calls it "a proposal way ahead of its time."
A Citation from Hoover
Former President Herbert Hoover, chairing a citizen’s advisory panel in 1956, cites the AHA and its Blue Cross Commission for aiding public welfare. Ray Brown, the AHA’s top elected member, receives the honor. The link with Blue Cross was dissolved a decade later.

George Bagbee
On his watch as chief executive, the AHA opened a permanent Washington office, pushed for passage of the Hill-Burton Act, and stepped up member services.

Making the Case for Medicare
As the health care troubles of the elderly repeatedly rose to the surface, the AHA’s Eisenhower-era Commission on Financing of Hospital Care pressed the case for a nationwide response.

Ameriplan’s centerpiece was the health care corporation, an organization charged with providing a complete range of care for people in its geographic area. Each corporation would cross political boundaries when necessary to ensure that everyone had access to care. “It was a forerunner of today’s integrated delivery systems and the current emphasis on community health,” said Perloff committee member Edward J. Connors, who served as AHA chairman in 1989. “Many changes in health care networking that parallel developments of the 1990s were embodied in Ameriplan.”

But AHA members sharply disagreed over Ameriplan. Some saw it as an invitation to the government bureaucracy it professed to avoid, while others feared its sweeping overhaul of the system. The AHA House of Delegates approved Ameriplan conceptually in January 1971 and several months later approved a policy statement on providing health services, which was drawn from Ameriplan. The AHA also endorsed basic provisions of a congressional bill substantially based on Ameriplan and introduced by former Rep. Al Ullman (D-Ore.), then the #2 Democrat on the House Ways and Means Committee.

Talk of major structural reform led the AHA to look at other basics. In 1969 and 1970, a committee developed the association’s first statement on health care for the disad-

A Mission in Motion: Words Change, but Basics Remain
The association’s first members set out to exchange ideas on the nitty-gritty of running hospitals. In doing that, they launched hospital management as a profession. The founders also put the mission of hospitals squarely on the side of patients and their communities. That remains fundamental today. In its centennial year, the AHA still flies the banner of community health improvement.

The evolution of the AHA’s mission over the past 100 years hints at major shifts in both health care and American society. These few words, revised and amended at various points for various reasons, show how the hospitals have perceived themselves and their role in the midst of technological, clinical, and policy changes.

1899: “To facilitate the interchange of ideas, comparing and contrasting methods of management, the discussion of hospital economics, the inspection of hospitals, suggestions of better plans for operating them, and such other matters as may affect the general interest of the membership.”

1907: “The object of this association shall be promotion of economy and efficiency in hospital management.”

1917: “To promote the welfare of the people so far as it may be done by the institution, care and management of hospitals and dispensaries with efficiency and economy; to aid in procuring the cooperation of all organizations with aim and object similar to those of this association; and, in general, to do all things which may best promote hospital efficiency.”
A Lakefront Home
A four-year, 100 percent hike in dues helped finance new headquarters on Chicago's Lake Shore Drive, with groundbreaking in 1959. Ten years later, the AHA added a west building with a connecting link.

At Long Last—Medicare
Harry Truman never saw his view of compulsory national health insurance made the law of the land, but he lived to see the advent of Medicare and Medicaid. President Johnson flew to Truman’s home in Independence, Mo., for the 1965 signing ceremony.

advantaged, but its work was far more sweeping. The statement held members accountable for all health care needs in their communities and described hospitals as central resources that must relate to all care providers and to all environmental, governmental, and social agencies in their regions. It also talked about the role of hospitals in preventing disease; maintaining and restoring health; improving services for the disadvantaged; and involving consumers in their health care decisions.

"Though more people are better served by hospitals now than in the early 1970s, many of the principles enunciated by the committee remain at the heart of the AHA’s vision for healthier communities,” said H. Robert Cathcart, a chair of the Committee on Health Care for the Disadvantaged and AHA chairman in 1976. Not surprisingly, the committee also created the landmark Patient’s Bill of Rights, which the AHA approved in 1973. That document stood unchanged until 1992, when it was revised by a panel on biomedical ethics.

In February 1972, following a national search, the AHA Board of Trustees appointed North Carolina Blue Cross executive John Alexander McMahon as the first president, the top staff position. At that time, the title of the AHA’s elected leadership position was changed from president to chair-

1938: “To promote the welfare of the people through the development of hospital and outpatient service. To further this object the association shall encourage professional education and scientific research, aid in the health education of the public, cooperate with other organizations having a similar object, and do all things which may best promote hospital and outpatient service efficiency.”

1951: “To promote the public welfare through the development of better hospital care for all the people.”

1973: “To promote the welfare of the public through its leadership and its assistance to its members in the provision of better health care and services for all the people.”

1987: “Its mission shall be to promote high-quality health care and health services for all the people through leadership in the development of public policy, leadership in the representation and advocacy of hospital and health care organization interests, and leadership in the provision of services to assist hospitals and health care organizations in meeting the health care needs of their communities.”

1995: “The mission of AHA is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement.”
Administering Medicare

AHA chief Edwin Crosby (left) looks on as Blue Cross president Walter McNerney signs a pact making Blue Cross a fiscal agent for Medicare. Social Security chief Robert Ball (right) signs his copy under the eye of Arthur Hess, head of the Bureau of Health Insurance.

Leaps in Medicine

Heart surgery pioneer Michael DeBakey of Baylor College of Medicine remains a symbol of major strides in medicine during the '60s and '70s.

National Hospital Week, 1967

With federal health regulation an increasingly potent force, the AHA became more visible on the policy scene and in the public eye.

sought to strengthen the AHA's visibility in Washington. Hospitals had already had a year of federal price controls under the Nixon administration's economic stabilization program; rarely had the association been so challenged.

Under McMahon, the AHA became embroiled in high-profile advocacy in defense of the field's interests. The AHA's concerns about rising hospital costs and the government's arbitrary attempts to control them peaked during the decade. In his 1976 report to the House of Delegates, McMahon vowed to "fight with every means at my command" President Ford's proposed cap on Medicare payments to hospitals, which the AHA believed would force members to cut services. McMahon's commitment to oppose caps on payments also dominated AHA advocacy through the Carter administration.

At the height of the Carter cap turmoil, the association rose to a challenge by Rep. Dan Rostenkowski (D-III.) to voluntarily control spending or suffer the consequences of government control. With the AMA and the Federation of American Hospitals (now the Federation of American Health Systems), the AHA organized the Voluntary Effort, aimed at reducing the rate of increase of community hospital expenses by 2 percent in both 1978 and 1979. The effort met with much cynicism. Yet within a year, the groups documented lower hospital spending and showed that percentage increases in the gross national product and in hospital expenditures from March 1978 to March 1979 were identical. The AHA's persistent opposition helped defeat President Carter's cost containment bill. Not long after, costs began to climb again, though more slowly. The Voluntary Effort's most significant victory was in unifying doctors and hospitals.

Throughout the 1970s, the AHA continued to focus on the problems of access to care and financing. It appointed an advisory panel to consider alternatives, including regulation of health care institutions as public utilities and state review of hospital rates. The House of Delegates even voted to propose federal legislation for national standards and guidelines for state rate review. But that position wasn't long-lived, since support for rate regulation proved shallow once the threat of more onerous measures decreased.

AHA advocacy increasingly called attention to the conflict between demands for quality care and cost control. As national health insurance again became a major issue, the association urged that any plan for universal health insurance combine cost containment with ways to moderate demand. It used the term "universal" rather than "national" to emphasize coverage for everyone versus a monolithic federal program. A landmark AHA document, a revision of the 1969 Statement on the Financial Requirements of Health Care Institutions and Services, declared that all purchasers of health care must recognize and "share fully" in the total financial requirements of hospitals.

As the association increasingly acted as both a defender of hospital interests and an advocate of broader public values, it sought to better understand the dichotomy. A committee—led by John M. Stagl, then president of Chicago's Northwestern Memorial Hospital and the association's chairman in 1977—declared that the AHA is both a trade group and a public interest organization, a distinction that underscored increasing involvement in national health policy. In 1978, the AHA formed a political action committee to increase its effectiveness in Washington.

As the association looked for new ways to balance heavy demands for health care with cost control, it turned to the business community. By 1985, more than 130 business and health coalitions had formed nationwide, and McMahon saw the need to work with business leaders on cost-effective solutions. He began meeting with these coalitions. Nationally, the AHA became part of a group of health, labor, and business leaders who studied health care issues under the leadership of John Dunlop, a professor at Harvard University and former U.S. labor secretary.

Also in the late 1970s, the AHA stepped up its interest in an emerging force known as managed care. Executive vice-president Gail L. Warden—who went on to become CEO of Detroit's Henry Ford Health System and AHA chairman in 1995—led discussions on HMOs, capitation, and related issues, frequently echoing concepts inherent in the Perloff report. "Forces outside the structure of the hospital field started to change 30 years ago when the Commission..."
on the Cost of Hospital Care talked about the hospital being the center for community health,” Warden said recently. “Now we’re seeing the reality, as hospitals are viewed as major social institutions, adding value to their communities.”

Warden was also the architect of the AHA’s constituency centers, which focus on the needs of multihospital systems as well as rural and urban hospitals. In response to a shortage of nurses, the AHA, the Hospital Research and Educational Trust, and American Hospital Supply Corp. sponsored the National Commission on Nursing. Participants included the American Nurses’ Association, the National League for Nursing, the AMA, the American Association of Colleges of Nursing, and academics. Its far-reaching recommendations spoke to nursing practice, education, and the public role in licensing and educational funding.

The field’s changing insurance needs led the AHA to form two subsidiaries in the 1970s: AHA Insurance Resource, which now serves the insurance, financial, and information needs of providers, and the Health Providers Insurance Co., a malpractice reinsurance company later sold in 1995.

McMahon affirmed the increasingly accepted view—for decades rejected by many hospital administrators—that governing boards should become more involved in the public arena, along with doctors and hospital executives. This position was strengthened officially by the AHA’s Committee on Hospital Governing Boards in its 1975 report and at the 1979 AHA Conference on Hospital Governance. At the conference, Sister Irene Kraus, former president of the Daughters of Charity National Health System and AHA chairman in 1980, told the audience to expect much more involvement from both trustees and consumers in health affairs. At the same time, the AHA insisted that the public had unmet responsibilities and should better understand its role in holding down costs and eliminating unnecessary and costly government regulations.

With Medicare costs continuing to sound alarms in Congress, the association’s Council on Finance recommended prospective pricing and diagnosis-related groups to control and better predict Medicare spending. After much debate, in 1982 the House of Delegates lent its support to PPS, and the AHA lobbied Congress to enact the system. AHA members continued to raise concerns about the system’s fairness, a dominant theme of the association’s policy deliberations. The association reconciled dozens of implications—geographic payment differences, wage issues, case mix adjustments, and socioeconomic differences among patients—first through its policymaking and then through advocacy.

At the same time, the field was growing increasingly alarmed about the effect of reductions in Medicaid and other programs that represent a safety net for the poor. The Special Committee on Federal Funding of Mental Health and Other Health Services (more popularly known as the Kinzer Committee after its chairman, David M. Kinzer, then president of the Massachusetts Hospital Association) produced a report, Health Care: What Happens to People When Government Cuts Back. It galvanized the association’s policy and strategy on Medicaid and other coverage issues. Discussions about the report also led to policy strategies to address care for the medically indigent. Most were later incorporated into the AHA’s proposal for overhauling the health care system.

The 1980s also brought new threats from infectious diseases to all hospitals. In a report laying out a hospitalwide approach to AIDS, the AHA dealt not only with patient safety and confidentiality, but also the safety of staff, personnel management, and public relations. In response to the growing bioethical dilemmas facing the membership, particularly in terms of life-sustaining care decisions, the association convened a committee of ethicists, administrators, nurses, and doctors to develop guidance.

In the early 1980s, a board committee headed by 1983 chairman E. E. Gilbertson took another look inward. The committee said the AHA should focus on hospitals and health systems as its primary institutional members and increase the voice of major constituencies in its policy structure. The constituency centers became “sections,” with governing councils and seats in the House of Delegates. The association’s council structure was refined, trustees became further involved, and multihospital systems received greater say in policy and governance. The AHA also recognized the influential role of nurse executives, leading to the establishment of the American Organization of Nurse Executives as an AHA subsidiary.

In 1986, when Carol M. McCarthy, Ph.D., succeeded McMahon as president, the association was deeply involved...
in debates over the future of Medicare and Medicaid. Steadily rising federal outlays continued to stir debate in Congress. Most Capitol Hill proposals were aimed at providers rather than beneficiaries, the least politically risky approach. Throughout McCarthy’s five years at the AHA, she battled changes that the AHA argued would threaten the quality of patient care and hospital solvency.

Association leaders increasingly saw that the existing payment system inevitably was ratcheting down payments year by year, and they began calling for fundamental changes. The Board of Trustees started work on health care reform principles that later guided the AHA through national debates in the early 1990s. “It was a big change for the association,” said McCarthy, “particularly in having to craft policies that might not protect the continuation of every one of its members in their existing structures.”

Growing competition, mergers, and other shifts in the market began to dominate discussions about the field’s future. At the same time, the AHA began to analyze its own role with an eye to streamlining operations and making participation more feasible for busy executives. The AHA standing councils were replaced by ad hoc committees that could complete their work on sharply focused issues in six months or a year. The Regional Advisory Boards became Regional Policy Boards. The Board of Trustees also set up an Institutional Practices Committee to oversee management guidance materials.

During McCarthy’s stint as president, the AHA began rethinking its programs and services, a process that continues under the presidency of her successor, Dick Davidson. “It was and is a sign of the times,” McCarthy said recently. “Associations are truly being challenged today to do more with less for a different type of member.” When McCarthy left the AHA, Jack W. Owen, who had been director of the Washington office since 1982, was named acting president. Owen, a veteran of Medicare wars on Capitol Hill, was instrumental in the association’s growing involvement in government payment policy.

The 1990s have brought the most sweeping changes ever to hospitals, the AHA, and all of health care. Organizations are merging, consolidating, acquiring, or being acquired more rapidly than at any other time in the nation’s history. Along with advances in medical technology, the integration of services is having a profound effect.
**Policy Voice**

Members are the experts: That’s the founding principle of today’s AHA advocacy and services. Gail Warden, CEO of Henry Ford Health System in Detroit and AHA chairman in 1995, lays out the AHA’s position in testimony to Congress.

Network Demonstration Program cosponsored by the AHA, the Health Research and Educational Trust, the Catholic Health Association, and VHA, an alliance of not-for-profit hospitals.

It was a small step from this view to the AHA’s new vision and mission based on community health and adopted in 1995: “The AHA vision is of a society of healthy communities, where all individuals reach their highest potential for health. The AHA mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement.”

In 1996 and ’97, the board and the strategic planning committee began reshaping the AHA to serve its changing membership in the next century. With the focus on the vision and mission, they aim to open up the AHA to new members, while keeping a strong emphasis on hospitals and systems. They’re considering ways to make dues more equitable and link advocacy and services to the new vision. Changes in governance and policymaking—and even the name itself—will be on the table during the 1998 centennial year.

With health insurance still a national concern, the AHA has embarked on a two-year Campaign for Coverage to reduce the number of Americans without health insurance by 10 percent—4 million people—within two years. The campaign draws on the work of state and metropolitan associations and commitments from members.

**Dick Davidson**

Since he took the AHA’s top job in 1991, the Office of the President moved to Washington to boost lobbying. He also has led a major rethinking of programs and services.

**Pacesetters, 1995**

Consultant Gerry McManis (left) leads a panel pondering trends in the field at the San Francisco convention: Gordon Sprenger, executive at Allina Health System and AHA chairman in 1996; Richard Scott, former CEO of Columbia/HCA; and Richard Neeson of Independence Blue Cross.

At the same time, the AHA has taken steps to restore public trust in the health care system. For 20 years, opinion polls have reflected the view that health care institutions are focused more on business needs than on patients and communities, an impression strengthened in the last year by the federal government’s efforts to define Medicare billing errors as fraud and abuse violations. The AHA has urged its members to adopt regulatory compliance programs to minimize errors and better conform to complicated federal rules.

On the merger and acquisition front, the association has developed guidelines for changes in hospital ownership that recommend detailed accountability to communities. The AHA also is sponsoring public opinion research and emphasizing patient involvement in decisionmaking as an important element of quality of care.

“The field has never lost its values of caring for people and trying to do a better job,” Davidson said recently. “The AHA has always felt a sense of accountability to communities.”

He’s optimistic about what this means for the future, “when health care organizations compete and collaborate at the same time.” Among his goals—based on his family’s experience since he became AHA president—is better treatment of patients at the end of life. “We have a long way to go, as we better integrate and coordinate care. And I hope we can help to make some inroads.”

Davidson sees incremental change—such as recent legislation expanding coverage for uninsured children—as the clear path for further reform of the health care system. “Incremental change has been our history in health care, and now we’re beginning to see change on that very basis,” he said. “It’s certainly evident in expanded choice under Medicare and in efforts to maintain choice in the workplace.”

Whatever unfolds at whatever rate, the AHA’s vision puts the association in a good position for growth and member advocacy, Davidson added. “Our mission dates from that first evening in Cleveland 100 years ago when a small group of hospital superintendents thought it was a good idea to get together. As history tells us, it was. And now we have an opportunity that none of us would want to miss.”

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**View from the Loop**

The AHA left its outdated Lake Shore Drive headquarters in 1994, moving its streamlined staff to One North Franklin in Chicago’s Loop.

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