

Editorial

Re-engineering

American business was expanding and prosperous during the fast moving 1980s. New services, and thus new jobs, were created. Layers of management were added. Salaries increased annually and the cost of living increase was relatively modest. As the nineties approached, the bubble of prosperity burst and a recession hit. This has forced companies to shut down or sell less profitable operations and to downsize working staff. Those who are employed are asked to work longer, harder, and smarter. This process has come to be known as re-engineering the American workplace.

For many years, medicine in the United States escaped the vagaries of the economic market place. Charges rendered as usual and customary were paid as such. During the last decade the percent of gross national product spent on healthcare has gone from single digits to double digits and is expected to approach 20% by the year 2000. The public, industry, labor, and government all feel this level of medical spending would be an untenable situation. Thus, healthcare in the United States is in for its round of re-engineering. President Clinton and the First Lady, Hillary, have made healthcare one of their primary agenda items in the new administration. Even without the government impetus for change in the method of healthcare financing and delivery, changes were already taking place

within the industry. Preauthorization for certain levels of care has become mandatory. This not only dictates the type and cost of the service, but also the length. In the early days of spinal cord injury care, it was usual for lengths of stay to be six months to a year. Better techniques in management had reduced those lengths of stay to three to four months. However, even that is not enough. More of the care will need to be rendered in less costly settings than those of a hospital. The re-engineering of spinal cord rehabilitation will necessitate experimentation with the day hospital concept and/or provision of some of the rehabilitation within the home setting. Other approaches will be developed by clever people within our industry who will respond positively to the challenge of providing quality rehabilitation in a less time consuming and thus less costly manner.

We must all look for ways to reduce cost and hopefully this will not alter the quality or diminish the outcome. As we analyze the options we must strive to be the ombudsmen for our patients so that they may be allowed a good outcome. The re-engineering of American medicine is underway and with it will come alterations in spinal cord injury care.

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