

Creative Retrenchment

*Proceedings of the Twentieth Annual Symposium on Hospital Affairs
April 1978*

Conducted by the Graduate Program in
Hospital Administration and Center for
Health Administration Studies, Graduate
School of Business, University of Chicago.

Table of Contents

1 INTRODUCTORY REMARKS

ODIN W. ANDERSON
Professor, Director
Graduate Program in Hospital Administration
Director
Center for Health Administration Studies
University of Chicago
Chicago, Illinois

2 CONSUMER COST SHARING VS. REGULATION: HEALTH POLICY AT A CROSSROAD

LAURENCE S. SEIDMAN
Assistant Professor of Economics and
Health Care Systems
The Wharton School
University of Pennsylvania
Philadelphia, Pennsylvania

8 DISCUSSION

11 THE DOCTOR-HOSPITAL RELATIONSHIP AND HOSPITAL COSTS

CARL STEVENS
Professor
Department of Economics
Reed College
Portland, Oregon

19 THE HEALTH SERVICES AGENCIES AND HOSPITAL COSTS

JAMES KIMMEY, M.D.
Director
Midwest Center for Health Planning, Inc.
Madison, Wisconsin

25 DISCUSSION

27 THE EXPERIENCE OF BLUE CROSS OF WESTERN PENNSYLVANIA WITH INDUSTRY AND LABOR AS TO COST CONTAINMENT

HOWARD GINDELE
President
Blue Cross of Western Pennsylvania
Pittsburgh, Pennsylvania

32 DISCUSSION

34 HOW INDUSTRY CAN HELP HOSPITALS CONTROL THEIR COSTS

JAMES MORTIMER
Second Vice President
Continental Illinois National Bank & Trust Company
Chicago, Illinois

40 DISCUSSION

42 PANEL DISCUSSION

LOUIS A. ORSINI
Vice President and Director
Health Insurance Association of America
New York, New York

S. MARTIN HICKMAN
President
Health Care Service Corporation
Chicago, Illinois

CARL STEVENS

RICHARD W. FOSTER, *Moderator*
Associate Director-Administration
Graduate Program in Hospital Administration
University of Chicago
Chicago, Illinois

55 THE MEDICAL STAFF AND COST CONTROLS

STEVEN A. SCHROEDER, M.D.
Associate Professor
School of Medicine
University of California
San Francisco, California

64 DISCUSSION

67 WHAT A HOSPITAL ADMINISTRATOR HAS DONE TO CONTAIN COSTS

LAD GRAPSKI
President
Allegheny General Hospital
Pittsburgh, Pennsylvania

71 PANEL DISCUSSION

HENRY P. RUSSE, M.D.
Chief of Staff
University of Chicago Medical Center
Chicago, Illinois

DAVID L. EVERHART
President
Northwestern Memorial Hospital
Chicago, Illinois

EVERETT A. JOHNSON
President
The Dunes Group
Chesterton, Indiana

LAD GRAPSKI

RONALD ANDERSEN, *Moderator*
Professor, Associate Director-Research
Center for Health Administration Studies
University of Chicago
Chicago, Illinois

80 LIST OF PARTICIPANTS

Introductory Remarks

CHAIRMAN ODIN W. ANDERSON

Welcome to the Twentieth Annual Symposium on Hospital Affairs sponsored by the Graduate Program in Health Administration and Center for Health Administration Studies of the University of Chicago.

This annual symposium is organized for the alumni of the Program, a form of continuing education. We try to present topics of current interest and significance. Since we are in a period of retrenchment in the health services, particularly for the hospitals, we thought that a symposium on meeting this problem intelligently and creatively would be of interest.

The planning for this program was greatly assisted by a committee of alumni working with the CHAS

staff. They are Donald Shropshire, Lad Grapski, John Imhoff and Ronald Spaeth. We wish to thank them for the contributions they made to shape this program. We have economists, insurance agencies, administrators, and big buyers like industries speaking at this symposium.

Finally, I wish to welcome the health administration students whom I hope will establish a habit of attending symposia in future years in spite of their being extremely busy in very important and high paying jobs in cost containment. In addition, I wish to welcome other people who are not alumni or students, whom I call friends and relatives of the program.

The Twentieth Annual Symposium on Hospital Affairs conducted by the Graduate Program in Hospital Administration and Center for Health Administration Studies of the Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on the University of Chicago's campus on April 28-29, 1978. These symposia are a reflection of the strong concern of the Graduate Program in Hospital Administration with complex current issues in health care management.

The topic for this, the Twentieth Symposium, was chosen by a committee of the Alumni Association because of its relevance in this period of changing environment for health care institutions. These proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

Special thanks are due Mrs. Margarita O'Connell and Mrs. June Veenstra, who not only staffed the Symposium, but also are in large part responsible for these proceedings.

Consumer Cost-Sharing vs. Regulation: Health Policy at a Crossroad

LAURENCE S. SEIDMAN

Odin W. Anderson, Professor, Director, Graduate Program in Hospital Administration, Director, Center for Health Administration Studies, University of Chicago presided over the first session.

CHAIRMAN ANDERSON: Our first speaker is Laurence Seidman, Ph.D. in economics, Assistant Professor of Economics and Health Care Systems, The Wharton School, University of Pennsylvania.

PROF. LAURENCE S. SEIDMAN: The U.S. health sector stands at a crossroad, and we must choose between two alternative strategies. The first is comprehensive regulation, and involves significant government intervention in the decision making of hospitals, physicians, and patients. The second is consumer cost sharing, and requires a radical restructuring of our health insurance coverage. I want to explain why I favor the consumer cost sharing strategy, how it can be implemented, and how it is supposed to work.

My argument will contain three parts. First, I will try to explain why we cannot maintain our present insurance coverage and avoid comprehensive regulation. Second, I will try to illuminate the central shortcoming of the regulatory strategy. Third, I will try to challenge the prevailing opposition to a consumer cost sharing strategy. I hope to persuade you that the use of a modern instrument of public policy, tax credits on the Federal personal income tax, should enable consumer cost sharing to be income-related, equitable, practical, and effective.

COMPREHENSIVE INSURANCE REQUIRES COMPREHENSIVE REGULATION

Currently, over 90% of all hospital revenues from patient care come from insurers—either private, or public. Although a minority of households continue to be inadequately covered, the overwhelming majority pay little or nothing out-of-pocket for their own hospital care. Physicians, acting as agents for their patients, have no incentive to weigh cost against benefits in selecting the hospital, medical services, or

length of stay, since patients naturally want the best, regardless of cost. In the absence of regulation, hospitals would respond to this demand by providing quantity, quality, and high style, regardless of cost. The result would be a rapid cost inflation, and misallocation of resources, which cannot be sustained indefinitely.

An analogy that captures the essence of the process is restaurant bill splitting. If it is agreed in advance that everyone will pay a specified fraction of the total bill, regardless of his own order, then each person has little incentive to restrain his order. Each therefore requests a higher quantity, quality, and style of food and drink, which the restaurant is delighted to supply. The result is cost inflation, and an escalating quantity, quality, and style of food and drink. The expense per person ends up much higher than the average person would order under individual checks, where each person must balance benefit against cost.

The same wasteful process could be induced in any sector of the economy simply by making the good or service free to the consumer. Let stereos be paid for by a third party, and most consumers would request the finest stereo, regardless of cost. Stereo producers would be only too glad to respond to this inflated demand. The result would be stereo cost inflation.

The solution almost everywhere in our economy is consumer cost sharing. In restaurants, we usually pay with individual checks. We pay for stereos out-of-pocket. Each consumer weighs the subjective benefit, as he perceives it, against the cost of each item, since he must bear the cost out-of-pocket. This weighing may be conscious or unconscious, rational or irrational. But the process prevents a wasteful absorption of resources in a given sector, without regulation. Moreover, the level and mix of quality reflects the subjective preferences of consumers, as each individual decides whether obtaining quality *A* rather than *B* is worth the additional cost.

Suppose, however, that consumer cost sharing is not permitted, perhaps because it is regarded as inequitable, so that the good or service remains free to the user. Then comprehensive regulation is inevitable. Society cannot allow suppliers to respond freely to the

inflated demands of consumers who have no incentive to weigh cost. Government will be required to intervene to try to restrict the demand of consumers, or supply of producers, or both. The hospital sector, like virtually any other sector of the economy, will be unable to avoid comprehensive regulation as long as its service is virtually free to the average patient.

COMPREHENSIVE REGULATION AND CONSUMER PREFERENCE

Free hospital care, facilitated by comprehensive insurance, leads to cost inflation. In response, new regulation is introduced to control cost. It is perhaps natural that the effectiveness of such regulation should be judged by the degree to which cost inflation is in fact reduced. Both supporters and opponents of such regulation have often accepted the criterion of cost reduction, but differed on whether regulation can in fact reduce cost.

I want to argue that cost reduction is the wrong criterion. The aim of health policy should be to achieve the right level of cost—neither too high nor too low. The objective should be to provide the quantity, quality, and style of service that best accords with each consumer's preference. Whenever the subjective benefit of additional quantity, quality, or style exceeds the additional resource cost required to supply it, it would be inefficient not to provide it. It is just as inefficient to provide too little as to provide too much. The goal should be to get the right level of quantity, quality, and style, and therefore cost, not only in the aggregate, but for each individual consumer.

Consumer cost sharing is the method used elsewhere in the economy to induce each consumer to reveal the urgency of his preference. Each person must weigh the cost of a good or service against its subjective benefit, because he must pay for it out-of-pocket. If two consumers have similar income, but the first is a music enthusiast, while the second merely likes music, then the first may seek a high quality, high cost stereo; the second, a low quality, low cost stereo. Stereo producers then respond according to this pattern of demand. It would be just as inefficient to provide low cost, low quality stereos to both as it would be to provide high cost, high quality stereos to both. If stereos are free, then both consumers will seek high quality, high cost stereos, and both will insist his preference is urgent. The central shortcoming of the regulatory strategy is that it has no effective mechanism for determining which preference is

urgent, and which is not. Let me illustrate with several hospital sector examples.

Consider the goal of achieving the right mean hospital stay—neither too long nor too short—and the right length of stay for each patient. Today, because of insurance, each physician recognizes that his patient does not bear the cost of each additional day, and therefore, would not want cost to influence the physician's decision. Under consumer cost sharing, the physician would recognize that his patient would want him to weigh the financial impact. If the additional day were still regarded as necessary, given the specific medical condition of the patient and options for home care, the physician would still prescribe it. Otherwise, the physician would discharge his patient. Without regulation, the physician and patient would have an incentive to weigh cost against benefit, and arrive at a decision reflecting this balancing.

The regulatory strategy must try to cope with the fact that patients and physicians have no incentive to weigh cost. Regulation can either attempt to reduce the demand for hospital days by physicians and patients, or the supply of days by hospitals, or both. Each will be considered in turn.

The attempt to reduce demand is usually called "utilization review." Physicians are requested to weigh cost, even though their patients would not want them to do so, and to discharge patients as soon as an additional day is no longer absolutely necessary. A review board is responsible for detecting cases in which the patient's stay has been extended "unnecessarily" and to provide some kind of sanction.

Utilization review raises a fundamental question: Can such an approach be sensitive to the differing medical histories and conditions of individual patients, and their differing subjective preferences concerning risk, comfort, and convenience? If a complex set of standards is to be applied sensitively to individual cases, then the administrative cost will be very large. Because hospital days are virtually free to the average patient, physicians and patients have an incentive to describe their own utilization as essential. The review board requires a large staff, composed of physicians and other trained personnel, to scrutinize a large number of cases. The review process also consumes an important fraction of the time of practicing physicians, who must respond to inquiries from the board. To distinguish essential from optional utilization in a sensitive way is, therefore, extremely costly.

If a simple standard is applied uniformly and strictly, administrative costs can be contained; but some patients who strongly prefer an additional day, based on their physician's advice, will not be permitted to have it. On the other hand, if a standard is simple but flexible, then it will have little effect, since physicians and patients have an incentive to assert their own utilization as essential, given the particular circumstances.

The irony of strict utilization review is that it would seek to prevent all medical care not regarded as absolutely necessary, at the same time that consumers are free to obtain optional goods and services in virtually all other sectors of the economy. For example, if a consumer wants the comfort of high quality furniture, or the pleasure of a high quality color television, he is free to obtain it, whether it is essential or not. Under strict utilization review, the same individual would not be allowed to stay an additional day simply because he valued highly its comfort and convenience.

The attempt to reduce the supply of hospital days can take two forms. Limits can be set on hospital revenues or costs; or limits can be set on physical capacity. Suppose both are tried. The hospital is given a ceiling on the revenue it can earn, and on the number of beds it can maintain. Together, it is expected they will reduce excessive hospital stays.

The assumption behind the supply restriction is that patients with legitimate, urgent needs will continue to receive the length of stay they require, and only patients with less urgent needs will be subject to a shorter stay. Unfortunately, it is far from certain that this will in fact occur. If utilization review proves ineffective, then in the absence of consumer cost sharing, physicians will seek additional days whether truly urgent or merely beneficial to their patients. If total demand exceeds the restricted supply, a shortage will occur, and there is no reason to assume that all patients with urgent needs will get the length of stay they require.

Now consider the goal of achieving the right growth rate of total hospital revenues, or physical capacity and technology—a rate neither too high nor too low. Elsewhere in the economy, cost sharing induces consumers to reveal their preferences, and supply responds to the pattern of demand. Suppose consumer spending rises 8% per year and, initially, consumers spend 8% more per year on both product *A* and product *B*. Suppose producers of *A* achieve a dramatic improvement in quality, while producers of *B* do not.

Then consumers might want to spend 10% more on *A*, but only 6% more on *B*. If producers of all products achieve quality advances comparable to *A*'s, then given their budget constraint, consumers may decide to spend only 8%, instead of 10%, more on *A*. The right growth rate of revenues for *A* depends on the preference of consumers for *A* relative to other products, and this in turn is influenced by advances in quality among alternative products.

Can the regulatory approach arrive at the growth rate that best satisfies consumer preferences? Without consumer cost sharing, patients and physicians inflate their demands, so that regulators cannot determine how strongly consumers prefer a hospital of quality *X* to a hospital of quality *Y*. Elsewhere in the economy, producers who raise quality and style discover whether consumers are prepared to pay the additional cost. If so, then the higher level will be maintained; if not, the producers must return to a more moderate level. In the hospital sector, patients and physicians will always be glad to receive a higher quality and style, regardless of cost. Thus, it will be extremely difficult for regulators to discover the intensity of consumer preferences, and to determine the growth rate that best advances consumer welfare.

To summarize, the basic shortcoming of the regulatory approach is that it has no effective method for ascertaining the genuine preferences of consumers, and therefore will be unable to ensure that resources are allocated in response to those preferences.

THE CONSUMER COST SHARING STRATEGY

It is often assumed that an attempt to introduce significant consumer cost sharing into the health sector would be inequitable, impractical, and ineffective. I want to explain why I believe the prevailing view is incorrect. The key to equitable consumer cost sharing is to utilize a modern instrument of public policy: tax credits on the Federal personal income tax.

An example will illustrate the tax credit approach to consumer cost sharing. Consider a household with an income of \$20,000. Under the medical expense tax credit, it might be required to pay out-of-pocket the first \$1,000 of its annual medical bill (5% of its income)—its deductible. It would then be entitled, on its Federal tax return, to claim a tax credit equal to 80% of its additional medical bill (a coinsurance rate of 20%), until its out-of-pocket burden reaches \$2,000 (10% of its income) which would occur when its annual bill reaches \$6,000. If its annual bill exceeds \$6,000, it could claim a tax credit equal to 100% of the excess, so

that its out-of-pocket ceiling would be 10% of its income.

Through the Federal income tax, each household's deductible, coinsurance rate, and out-of-pocket ceiling could be varied with its income, so that the subjective burden of out-of-pocket expense would be comparable for households in all income brackets. The tax credit would replace the current medical deduction, which provides a subsidy rate that increases, rather than decreases, with income. A medical tax credit schedule on the income tax Form 1040 would enable consumer cost sharing to vary with income, while preserving confidentiality. Households with low incomes which do not currently file a return would now file for the sole purpose of claiming the medical tax credit. The credit would be refundable, so that a household would receive a check from IRS if its credit exceeds its tax liability. A medical tax credit bill with this basic design has been introduced in Congress by James Martin of the Health Subcommittee of the Ways and Means Committee.

As I have explained elsewhere, several complementary policies are required. First, medical loans must be guaranteed to households unable to afford immediate payment, so that the cash flow problem is managed until the annual tax return is filed and processed. I have suggested that private health insurers, as well as banks and loan institutions, might perform this function under contract with the government. Private health insurers would continue to process and pay most hospital bills on behalf of patients. This would assure prompt payment for hospitals. When the annual tax return has been processed, IRS would use the household's tax credit to repay the private insurer, who would then bill the patient for the remainder which is subject to consumer cost sharing. If private health insurers shift from insurance to medical loans, the consumer cost sharing strategy will not harm these companies.

Second, current tax subsidies to workplace health insurance should be eliminated, as most health economists have recommended. Currently, if an employer pays an employee \$100 in the form of cash salary, perhaps \$30 of tax must be paid, so that the employee benefits only \$70. If the employer pays the \$100 in the form of a contribution to health insurance, no tax is owed. This artificial subsidy is one primary reason why first dollar hospital insurance is widespread. It is a central cause of hospital sector inflation.

Third, if an employer offers health insurance to his employees, he should be required by law to offer each

employee the option of taking an equivalent amount of cash salary instead of the insurance. Together, the elimination of the workplace subsidy and the cash-equivalent option would ensure that each household obtains additional insurance, beyond the protection provided by the medical tax credit, only if it values such insurance more than its cost.

Fourth, it should be emphasized that a household can only claim tax credit on its own out-of-pocket expense for medical care, not on the expense of a health insurer on its behalf. It is, therefore, impossible for a household to obtain private insurance to cover its cost sharing under the tax credit, because its cost sharing is not determined until after it has decided whether to obtain private insurance. In effect, IRS goes last, setting the tax credit only after the household has chosen to be insured or uninsured, and basing the credit solely on the household's own expense, not the expense of its insurance company. Only if IRS went first, setting the tax credit according to the medical bill itself, could a household obtain insurance that would cover whatever IRS does not. Thus, the only way for a household to eliminate cost sharing would be to buy complete private insurance that covers its entire medical bill. The premium for such complete insurance would be substantial.

If these policies are enacted, it seems plausible that many households will regard the Federal medical tax credit as sufficient insurance, and will not purchase supplementary private insurance. The result would be that every household would be fully protected against a medical bill that is large relative to its income. The average household, however, would pay a fraction of its own medical bill out-of-pocket, so that consumer cost sharing once again would become a central feature of the health sector.

The tax credit would enable each household to choose between fee-for-service physicians and hospitals, and health maintenance organizations. Whichever the household chooses, it would receive a comparable credit for a fraction of its out-of-pocket expense. The tax credit would, therefore, promote consumer choice, and encourage a healthy competition between fee-for-service providers and HMOs.

The significance of the tax credit is that it enables consumer cost sharing to be income-related in a confidential, feasible manner. It has only been in the last several decades that our tax system has become sufficiently sophisticated to handle such an assign-

ment. Historically, concern for access to medical care preceded the development of a personal income tax that covered the vast majority of the population. In this country, the Federal income tax was first enacted in 1913, and for many years covered only a small fraction of households. In the late 19th and early 20th centuries, in Europe and the United States, the only way to assure that all households could afford the medical care they required was to make it free. This could be done by comprehensive private insurance, or public insurance, or by state-owned and operated hospitals financed by taxation. In this context, the attempt to preserve consumer cost sharing would have perpetuated hardship, since charges would have been oppressive to households with medical bills large relative to their income.

The implication of a sophisticated personal income tax for health policy is just beginning to be recognized. For the first time, it has become possible to income-relate consumer cost sharing. Every year each household must confidentially report its income to IRS. Through the medical tax credit, it can be financially assisted according to its income. Hospitals and physicians can charge prices to individuals regardless of their income, and IRS can reimburse a fraction through the tax credit. In this way, consumer cost sharing for medical care can be made equitable. Therefore, it has become possible to preserve consumer incentives for efficiency without sacrificing equity.

THE IMPACT OF CONSUMER COST SHARING

Even if it is granted that consumer cost sharing can be made equitable and practical through tax credits, the question remains: would it be effective? I am convinced that skepticism is often the result of a misunderstanding about the way in which cost sharing is supposed to work.

It is widely assumed that advocates of consumer cost sharing expect patients to shop around for hospitals, frequently ask the price of particular medical services, and even delay emergency operations until the prices of alternative operating rooms have been ascertained. If cost sharing strategy depended on such behavior I, too, would share the skepticism.

The physician, acting on behalf of his patient, must play the key role in the process. For the strategy to work, at least a minority of physicians must begin to weigh the financial impact on the patient.

Under a system of medical tax credit and complementary policies, physicians would soon

recognize that a radical restructuring of insurance had occurred. Previously, the average patient paid virtually nothing out-of-pocket for hospital care, and therefore, naturally expected his physician to select the most costly hospital and medical services. Now, the average patient would pay out-of-pocket a fraction of the cost of his own hospital care. He would want his physician to avoid unnecessary expense wherever possible.

Most physicians would admit patients to hospitals only when necessary, and would discharge each patient as soon as the benefit from an additional day was outweighed by the fraction of the cost borne by the patient. Previously, when hospital care was fully covered by insurance, rather than resort to home care, physicians and patients often preferred to extend the length of stay. Now, in the same circumstances, they would prefer to shorten it. The essential point is that the physician, in light of his patient's particular medical history, condition, and subjective preference, would weigh benefit against cost in deciding the appropriate length of stay.

Is it realistic to expect physicians to behave in this way? At the time of the decision to admit, or to extend the length of stay, the average patient may be preoccupied with his medical problem, and will acquiesce in whatever decision his physician makes. Two months later, when he receives his medical bill, and estimates the fraction he must bear out-of-pocket, he will undoubtedly reconsider his physician's behavior. Some patients will ask their physician: Did I really require all of those tests? Did I really need to be in the hospital on the 10th day?

Those physicians who take seriously the trust relationship will anticipate such concerns, and try to reduce cost whenever it would not sacrifice quality or comfort that the patient would prefer. Other physicians will want to minimize complaints from patients to avoid a reputation as a physician unconcerned about the financial burden of his patients. A combination of ethics and self-interest should cause many physicians to begin altering their behavior. Sensible malpractice reform would further reinforce this process.

Perhaps the most important change would be the criteria by which physicians select a hospital for each patient. Suppose hospital *A* provides the most advanced technology, quality, and style, and charges \$300 per day, while hospital *B* provides a more moderate quality and style, for \$150 per day. When hospital care is free, patients want their physician to

select *A* rather than *B*. In fact, to compete successfully for patients and physicians, *B* would probably be forced to match the technology, quality, and style of *A*.

Charging the patient a fraction of the cost changes the situation significantly. For a minority of patients with particular medical conditions, *A* would still be preferred. The higher quality would be worth the additional cost, and physicians would still select *A* for these patients. For a majority of patients, however, physicians would recognize that their patients would prefer *B*, if they possessed the same medical knowledge as their physician. These patients would conclude, were they so informed, that for their particular problem, the additional technology, quality and style of *A* is not worth its additional out-of-pocket cost. For these patients, physicians would choose hospital *B*.

Even if only a minority of physicians behaved this way, the impact on hospital behavior would be very significant. Under cost sharing, to attract this minority of physicians and patients, hospitals would have to provide only the level of technology, quality, and style that physicians, as agents for their patients, judged to be worth its out-of-pocket cost. Moreover, hospitals would have to improve their technical efficiency to provide a given quality at minimum cost, since many physicians would now choose a less costly hospital offering the same quality as a more costly hospital. In any other sector of the economy, an active minority of consumers is sufficient to make producers respond since they can make the difference between profit and loss. Even if a majority of physicians ignored cost sharing, hospitals would be forced to respond to the minority who did not. All patients would benefit from this change in hospital behavior.

In response to the new attitude of at least a minority of physicians, a mix of qualities and styles would be offered by hospitals, just as occurs in other sectors of the economy. Whenever a physician believed his patient would prefer a more expensive quality, despite its cost, he would choose the hospital that provided it. Otherwise he would select a less costly hospital. In this manner, the right level of quality, style, and therefore cost per day, would be approximated. The right level is that which consumers prefer, in light of the cost which they must partly bear. It must be emphasized that because the tax credit would be income-related, low income patients would be as capable of affording expensive care as high income patients. Choice would depend on preferences, not income.

The growth rate of hospital revenues, and the average cost per day, would be determined by consumer preferences, as registered through physicians, on the consumers' behalf. If significant advances in quality occurred to the extent that patients preferred incurring the associated cost, then the growth rate of hospital revenues, and the average cost per day, would be higher than if only modest advances were forthcoming.

Under consumer cost sharing, a patient and his physician would be able to obtain the quantity, quality, and style of service that they believed, given the patient's particular medical history, condition, and subjective attitude towards risk and convenience, was worth its out-of-pocket cost. There would be no external regulators to interfere with the decisions of physicians and patients, or the attempt of hospitals to respond to the resulting pattern of demand. Cost sharing would eliminate the ironic situation achieved by the regulatory strategy under which consumers are free to obtain non-essential goods and services elsewhere in the economy, but are not permitted to obtain additional quantity, quality, or style of medical care unless it is absolutely essential. The freedom of each patient, guided by his physician, to obtain medical care that a regulatory board might call "optional," but that the patient and physician judge to be worth its out-of-pocket cost, would be preserved.

CONCLUSION

Comprehensive insurance inevitably requires comprehensive regulation to contain the cost inflation it would otherwise induce. Makers of health policy must choose between comprehensive regulation, or a radical restructuring of health insurance so that consumer cost sharing becomes widespread. The fundamental shortcoming of the regulatory approach is that it has no effective mechanism for ascertaining genuine consumer preferences; it is unable to ensure that resources will be allocated according to these preferences. I have tried to explain why consumer cost sharing can be equitable and practical, through the modern instrument of tax credits, and why it promises to induce resource allocation that best accords with consumer preferences, and therefore, best promotes people's welfare.

DISCUSSION

with Laurence S. Seidman

CHAIRMAN ANDERSON: That was a straightforward explication of economic theory. Prof. Seidman is open to questions.

MR. PAUL A. HOFSTAD: Unless the doctor is really involved in this dollar exchange between the third party payer and the hospital, I wonder if he is really going to take that kind of interest and take that amount of time in responding to the quantity, the quality, and the style that the patient would want?

It would seem that if the doctor did the billing on behalf of the patient, and got involved in that dollar exchange, the doctor would have a great interest. But I am not quite sure how you can get this response from physicians by what you are proposing.

PROF. SEIDMAN: Today, I think that most physicians assume correctly that hospital care is not burdening their patients financially, and they then proceed to develop practices and procedures with that basic fact in mind.

If we were to reverse that, if now a physician knows that, in general, his patient is bearing a fraction of the cost of everything that is prescribed for him—I think that at least a significant minority of physicians will begin to reverse their rules of behavior. The physician will not know what fraction of the cost his patient will bear; after all, that is determined confidentially between the patient and IRS later on. But he will have that awareness, which will then be reinforced by the fact that at least a minority of patients will verbally express concern to the physician, for the first time, about the cost of the hospital bill and services. This may occur, not at the time of the illness, but perhaps two months later.

In general, physicians will know that any time they do something at a hospital, it will be costing their patients something. They will be likely to hear about it from some of their patients. Some will be motivated ethically to say: "Look, I know that I can save the patient money without sacrificing quality. Wherever possible, I will do that. I may also want to make the point to my patient, who will appreciate it."

There are others who, just as a matter of self-interest, won't want to be barraged with complaints

which they will have difficulty in answering. For example, I know of one case where someone was waiting for the results of a biopsy and asked the physician whether to wait at home or stay in the hospital bed for that day. It was a very casual thing, and the doctor said, "Why don't you just wait here?" This, I think, was about ten o'clock in the morning, and the check-out time was noon. The results were supposed to come about three o'clock.

If that patient had had to pay a reasonable fraction of the cost, which was not the case, I know that he would not have stayed, and I can't believe that the physician would have thought twice about saying, "Just wait at home, and we will call you." But that patient stayed, and the physician didn't think twice about saying, "Wait here," because it was free to the patient.

We are not interested in eliminating those decisions where people would say, "Look, in spite of the cost, this is important. This is essential." Those are exactly the services we still want people to get.

What we are looking for is the optional range, those situations where the knowledge that people are paying a fraction of the cost will cause the physician and the patient together to say, "Let's not use that particular service."

It is such a radical change from the environment that has been evolving over the last twenty years that it is hard to imagine how differently physicians will respond. I am not saying things will change overnight, but don't underestimate how accustomed we are to this climate of free care, and how all of the behavioral patterns that we see among physicians and in hospitals are influenced by it.

MR. DAVID M. HATFIELD: Under this system, do you see the patient sharing part of the malpractice insurance premiums for both the doctor and the hospital since there is an agreement on some kind of risk taking?

PROF. SEIDMAN: No, I am not prepared to set out what I think is the best way to handle the whole malpractice problem. I added the sentence saying that sensible malpractice reform will help in the process I

am envisioning because, clearly, if physicians have to put covering themselves for malpractice as their number one concern at all times, then that tends to drive a wedge between the physician and his patient. I am not ready to set out for you the best way of handling that. I think that it is a tough issue, but we have to improve on it for this process to work.

MR. ALEXANDER HARMON: I am wondering about the incentive problem we are going to run into with the labor union member who has already bargained total benefits for health care and finds that he may have to retrench and begin to share costs, and sees it as a loss of some benefit.

PROF. SEIDMAN: In the complementary policies that I described, people would be absolutely free at their workplace, if they bargained for it, to receive additional supplementary private health insurance. My complementary policies did two things. First, every employee would have the option of taking the equivalent amount of cash instead of that insurance, and second, the tax advantage of having the employer's compensation appear in the form of health insurance rather than cash salary would be eliminated. You would have a union worker who has the opportunity to take a hundred dollars in cash or get additional private insurance. If he wants the additional private insurance, this proposal would in no way interfere with his freedom or ability to get it.

What would be different, is that for the first time individuals at their workplace would be able to weigh whether they would prefer to have the \$800 in cash or in the form of insurance coverage.

Historically, it was the fear that people would take the money, not the insurance, that caused Congress to enact the special tax advantage. I think that there was good reason for that policy because people could end up in trouble later on if they were shortsighted. Under this medical tax credit, which would create an out-of-pocket ceiling that varied with people's income, even if someone didn't buy additional insurance, he could never be burdened out-of-pocket more than, say, 10% of his income. There would be no danger that if someone didn't buy additional insurance he could severely jeopardize himself or his family. All we would be saying to the union worker is: "You are free to buy the additional insurance, but there is no longer an artificial tax subsidy, and you are free to take the cash."

Why is it penalizing the worker to give him the opportunity now to take the cash? I am a worker at a

university that gives me no choice. We don't have the opportunity now to choose.

MR. J. JOEL MAY: You have partly answered the question I was going to raise about the role of reinsurance in this world of yours. It seems to me there might be an advantage to the consumer to reinsure the out-of-pocket cost simply because of the short-run cash flow implications and the cost of borrowing money to pay the bills. Unless you preclude reinsurance, you run the risk of getting right back into the distortions that we have now.

PROF. SEIDMAN: The cash flow problem is very important. I had an article in *Health Services Research* last summer which dealt specifically with the medical loans policy that has to complement this. If you are not guaranteeing access to loans for people under this tax credit approach, then I think you are right. Then people will feel: "If I have to come up with the money, I can't wait a year until my tax return is filed and processed. I had better go and get insurance." They will obtain insurance as much for the loan cash flow function as for avoiding the risk.

What you ought to do is make sure that government contracts with private companies and here I would see a major role for private insurance companies to provide that loan function. It could work something like this. Each year after filing the tax return, people could receive a health credit card that would come back encoded from IRS indicating their previous year's income, and that could be used during the following year for access to loans, so that the lower income groups in particular would have immediate access to a hundred percent loan; upper income groups perhaps to just a fraction of the total bill. What you would get is private health insurance companies continuing to get the bill from the hospital, processing and paying the bill just as they do today. The hospital would continue to be promptly paid. At the end of the tax year, when the tax forms had been filed and processed, the government would reimburse its part of the loan, and the patient would be billed for the remainder of his expenses.

Now again, it is certainly true that a credit card to some degree encourages people to use more, but it is completely different from knowing that you will never pay, to knowing that you have a loan. We may spend more in department stores when we have credit cards,

but if, when we obtained something at a department store it was completely free and we never had to pay the bill, people would drive trucks up to stores and empty them out in a day.

The difference is that the loan function does not undermine the basic cost sharing strategy, but it is very important that we take care of it.

MR. DAVID H. KLEIN: How would you control unintended benefit expansion? For example, you have a provider that is treating psychiatric illness, and he decides he is going to go into a whole array of services related to, say, spiritual healing or marriage counseling or whatever.

Where do you get controls to make sure that the services that the providers have rendered are, in fact, what the government intends to be paid for?

PROF. SEIDMAN: Any form of financial assistance to

people for medical care, whether it is through the tax credit approach that I talked about, or any of the myriad national health insurance bills, must all wrestle with the issue of which expenditures will be qualified for reimbursement. The tax credit approach is no better or worse than any of the others. You are going to have tough questions on where to draw the line on what constitutes a bona fide medical expense.

It is important, I think, that you try to be broad in what you would allow to be covered. That way you don't create the kind of situation that we now have where, for example, you are reimbursed completely for hospital care, but often not for care in the home, and therefore, people's behavior is distorted.

As a general rule, you want to be broad in what you allow to be reimbursed. On the other hand, you obviously have to draw the line at some point. That is a problem common to every approach that tries financially to assist people with medical care.

The Doctor-Hospital Relationship and Hospital Costs

CARL STEVENS

CHAIRMAN ANDERSON: Our next speaker has reduced the problem, according to the title, to the doctor and the hospital, and at least in the title left out insurance, so perhaps he simplified the problem.

I am very pleased to present Carl Stevens, Professor, Department of Economics, Reed College, Portland, Oregon, who has been working in this field for a number of years.

PROF. CARL STEVENS: It's a pleasure to be here with you for this Twentieth Symposium. I listened carefully to Professor Seidman. In my view, you have all received a good bit of common sense. I hope you likewise listened carefully to Professor Seidman. I agree, I think, with almost everything he said, with the qualification that I don't think he went far enough. And I don't think he went far enough in the sense that he did not go on, as I will attempt in some places to do, to explore possible obstacles to the suggested remedy for the position.

To some extent, I suppose Professor Seidman gave bits of my speech. This will lead me to try and delete parts of my speech without producing a nonsequential account.

I think I will follow his lead and more or less read from my prepared statement to get as much as I can into what is a rather brief period of time.

An understanding of the physician-hospital relationship is central to an understanding of the economic performance of the hospital sector. It seems that regulators and would-be regulators of the health sector have been slow to appreciate this point, and this failing has contributed to cost-control prescriptions which are not tailored to the structure of hospital management decision-making. This lack of insight has in turn contributed to the failure of hospital regulation programs to achieve their objectives. Are there remedies for the position? In what follows, I will make a few suggestions on this score.

I would like at the outset to make a general point. Modifications of the physician-hospital relationship belong to that domain commonly referred to as "market structure planning strategies." Other

prominent members of this domain are modifications of the physician-patient relationship and modifications of the way in which the demand for health care is financed. As a way to improve the efficiency of health sector performance, each market structure strategy works best in concert with the others—and collectively they represent, in principle at least, a promising alternative to the wave of public-utility-type regulation and central planning which now seems to be engulfing us and in which, I might add, I have absolutely no confidence whatsoever. I was very pleased to learn from my inspection of the preliminary program format for this Twentieth Annual Symposium that this program apparently was to be directed in good part to market structure concerns.

It struck me as I wrote that, after all, here at the University of Chicago I should have expected this much wisdom. It turns out, as a matter of fact, that it is not possible to talk as one would like to talk about the physician-hospital relationship without also, to some extent, talking about these other market structure planning strategies. I will, to some extent, necessarily touch on some points made by Professor Seidman.

Turning now to my topic: the hospital is basically a facility used by physicians in their own practice of medicine. It is a facility used jointly by a group of independent businessmen who themselves have a direct financial relationship to the patients admitted to and billed by the hospital. The physician decides what patients are to be admitted, what hospital services they shall utilize, and what their lengths of stay shall be.

As Ray E. Brown pointed out many years ago: "No other form of organization can equal the obstacles to tranquility that are present in the medical staff-administrative-trustee triangle." And speaking of the medical staff, Brown made the central point: "While they (referring here to the medical staff) ... are not stockholders in the hospital, they have a deep, abiding proprietary interest because their livelihood, to an ever-increasing extent, is dependent upon the hospital."¹

In part pursuant to their "deep, abiding proprietary

¹ Ray E. Brown, "Hospital Tensions Threaten Tenure," *The Modern Hospital*, 72, No. 5 (November 1949) p. 52.

interest," staff physicians effectively urge their hospitals to expand capacity and upgrade the quality and sophistication of services. Comprehending such factors, some years ago my analysis of the physician-hospital relationship led me to conclude: "the supply response of the hospital sector ... (the capacity of the sector) is predicated not upon some non-profit motive of the hospitals as enterprises per se, but rather upon the for-gain motives of the individual practitioners who want to use these facilities as a necessary adjunct to their own business operations."²

There are, of course, important dimensions of the physician-hospital relationship in addition to those suggested by appeal to business or marketplace considerations. Thus, although physicians are marketers, they are also "professionals"—and as such they enjoy the rights and carry the obligations associated with the professional role. As a part of this, it is not, of course, necessary for the physicians to have membership on the hospital governing boards in order for them to share authority, as they do, in the governance of the hospitals they are attached to. Indeed, the physicians are characteristically the dominant members of the so-called management triangles.

Much more could be said to describe the physician-hospital relationship. However, in this forum, this is familiar ground; we need not rehearse it in detail. Of course, not all physician-hospital relationships are the same. Nevertheless, the most valid and, for present

purposes, analytically useful characterization is that which stresses the dominant role of the physician in it. A major, proximate consequence of this is, as Victor Fuchs has put it: "From the point of view of the hospital administrator, running a hospital is like trying to drive a car when the passengers have control of the wheel and the accelerator. The most the administrator can do is occasionally jam on the brakes."³

HOSPITAL CONTROL PRESCRIPTIONS ARE NOT TAILORED TO THE STRUCTURE OF HOSPITAL MANAGEMENT DECISION MAKING

Most regulators and would-be regulators of the hospital sector seemingly do not appreciate the significance for their cost-control programs of physicians' dominance of the hospital management triangle. Prominent cost-control strategies are addressed to an entity called "the hospital" (represented by the administration and/or the governing board) and seem implicitly to regard this entity as decisive for the design of hospital-services production functions, rates of output of hospital services, and so on. However, it is the staff physicians who are decisive on these scores. Policy and analytic focus on "the hospital" leads to neglect of the dominant role of the physicians in the whole decision-making process.⁴

Supply control by certificate-of-need (CON) regulations are illustrative of the problem here alluded to. As one who has (as a member of the Oregon State Health Commission) shared an attempt to administer a certificate-of-need program, I can testify that it is not possible to regulate a hospital's physical plant and equipment without at the same time regulating patterns of medical practice. In evaluating the consequences of regulating hospital capacity, the central questions concern the response-behavior of physicians. But ostensibly and *de jure* the regulations are addressed to "the hospital," not physician behavior.

Of course, in the hospital sector or any other, if plant capacity is fully utilized already, then reducing it will reduce output. But this approach, albeit vigorous,

² Carl M. Stevens, "Hospital Market Efficiency: The Anatomy of the Supply Response," H. Klarman, ed., *Empirical Studies in Health Economics*, Baltimore, The Johns Hopkins University Press, 1970, p. 235.

Mark Pauly and Michael Redisch developed a hospital model (see their "The Not-for-Profit Hospital as Physicians' Cooperative," *The American Economic Review*, March 1973) based upon the same kind of assumption, viz., p. 88:

The critical assumption of our model is that the physician staff members enjoy *de facto* control of hospital operations and see to it that hospitalization services are produced in such a way as to maximize their net income.

This assumption, while an improvement over assumptions which do not recognize the central role of the staff physicians, is too strong. In my view, a more appropriate model of the hospital decision-making process is one which explicitly recognizes a bargaining relationship between the staff physicians and the administration board. This bargaining process entails, in effect, administration board "mediation" and "arbitration" of competing claims of the various staff physicians. It also entails administration board attempts to conserve and protect institution interests including those which may be threatened by environmental constraints. I must confess that this view results in a rather complicated model of the hospital decision-making process. However, in this domain, complication is necessary to achieve even a barely adequate representation of reality. In my view, simple maximization-type models of the hospital decision-making process are unlikely to do much scientific work.

³ Victor R. Fuchs, *Who Shall Live*, New York, Basic Books, Inc., 1974, p. 58.

⁴ Some useful recent discussions which do not share this fault are: J. Harris, "The Internal Organization of Hospitals: Some Economic Implications," *The Bell Journal of Economics*, Autumn 1977; and Michael A. Redisch, "Physician Involvement in Hospital Decision Making," in M. Zubkoff, I. E. Raskin, R. S. Hanft, eds., *Hospital Cost Containment*, New York, Prodist for Milbank Memorial Fund, 1978.

cannot be held to address itself in any discriminating way to the underlying market and organization dynamics which are responsible for the problem of high rates for utilization of hospital services.

Grabbing the bull by the horns in this way might work—that is, the system response might be such that the underlying market dynamics are brought efficiently into line with the CON-imposed capacity constraints—as CON regulators seem implicitly to assume. However, there is a high probability of an inefficient and perhaps untoward system response to the CON-imposed constraint, e.g., intra-hospital warfare may break out as the physicians struggle to maintain their shares of the diminished capacity of the hospital to respond to their orders for hospital services.⁵

Hospital rate setting, or regulation in one way or another (which, along with CON, belong to the public utility approach to cost control) is also illustrative of the problem of the failure to tailor control prescriptions to the structure of the hospital management decision-making process.

Rate setters and prospective budgeters hope to squeeze hospitals enough to induce greater operating efficiency, presumably without endangering the quality of care, and without cutting off access to “needed” services.

Like CON regulators, the rate setters and prospective budgeters address their activities to “the hospital” and do not appear to devise strategies which attempt to engage physicians’ behavior directly. Presumably, the hospital administrators, more acutely aware than anyone of the crucial role physician behavior plays in determining costs, are supposed somehow to back-seat drive their medical staffs pursuant to moderating cost inflation. Kate Bauer, in warning about the difficulty of summary characterization of the diverse domain of rate setting programs, remarks: “In fact, as will be seen, there is considerably more commonality in the activities rate setting agencies *fail* to pursue than in the ones they do pursue. As a major example, no program aims its reimbursement risks and incentives at the physician members of hospital staffs, although all fully recognize that the day-by-day decisions such physicians make in hospitals are by far the most cost-consequential ones.”⁶

The regulator’s proclivity to focus on “the hospital”

⁵ See Harris, previously cited, for some discussion of the problem of rationing hospital capacity among the members of the medical staff.

in such a way as seemingly to neglect the central role of the staff physicians appears to be almost irresistible. In an article advocating a program of voluntary hospital cost controls, the authors comment: “There are few incentives—and in most hospitals there are no rewards—for administrators and trustees to reduce unnecessary hospital admission, length of stay, and overutilization of laboratory, X-ray and other ancillary services.”⁷ This may well be true, but what warrants remark is that it is the *staff physicians*, after all, who admit, determine length of stay, etc., so that regulation strategies should address incentives to them more directly than is implied by devising incentive programs for administrators and trustees.

Under conventional programs, rate-control regulators must rely on the hope that administrators and trustees will respond to incentives for cost-control by attempting to ride herd on their medical staffs. This hope, however, may be little more than wishful thinking. For one thing, administrators and trustees are at a disadvantage in their bargaining relationships with the medical staff as a consequence of information inequality. Moreover, there are various intra-organization incentives for administrators and trustees to cooperate with and to accommodate their medical staffs. Under these circumstances, if incentives for cost control directed at administration are to be effective, they must be at least strong enough to countervail the opposing incentives. In any case, even sufficient incentives to countervail and motivate the administration to attempt to ride herd on the medical staff by no means assures success in that enterprise.

THE PUBLIC UTILITY/PERFORMANCE TARGET PLANNING APPROACH: LITTLE REASON TO SUPPOSE IT WILL WORK

CON and rate regulation may be characterized as the public utility approach to cost control. Many students of these matters have little confidence in the efficacy of this approach. For one thing, health

⁶ Katherine G. Bauer, “Hospital Rate Setting—This Way to Salvation?”, in M. Zubkoff *et al*, *Hospital Cost Containment*, p. 326.

Bauer provides an excellent summary of the central features of these programs and an excellent general evaluation of rate setting as a regulatory mechanism.

⁷ R.I. Schulz and Jerry Rose, “Can Hospitals be Expected to Control Costs?”, *Inquiry*, June 1973, p. 4.

services researchers are beginning to learn what every student of Soviet-type, centrally planned economies knows (and what every would-be regulator and student of regulation should know—but frequently seems not to) namely, that regulation of most any kind will almost certainly provoke unwanted responses which may well frustrate the intentions of the regulator. In any case, and recognizing that the jury is not yet in on the question, we can say that there is, to date, little evidence to support the belief that CON and rate regulations can play a significant role in cost control.⁸

CON, rate setting and, indeed, the planning called for by P.L. 93-641 belong to what may be termed the “performance target approach” to health sector planning and cost control. I do not engage the issue of whether the planning called for by P.L. 93-641 can be expected to improve the efficiency of health sector performance, albeit I may confess to grave doubts on this score. P.L. 93-641 represents a fascinating attempt to impose central-planning-type planning on a largely decentralized, private health care sector. Whether it will “work,” in the sense that market performance is different than it otherwise would have been in consequence of ministrations pursuant to the Act, depends partly on the goals represented by the plans. More crucially, whether it will work in this sense depends upon whether the plans can be implemented. If not, the legislation is of little real significance. Although the legislation mandates the implementation of HSA and SA plans, it is notably silent with respect to implementation strategies. CON appears to be about the only significant one explicitly provided for. It will be interesting to see what the importance of the Secretary’s (DHEW) “guidelines” will be from the point of view of plan goal definition and plan implementation.

A major alternative to performance target planning is, as I mentioned at the outset, “market structure planning.” With this approach, the effort is to achieve efficient market structures which may then be relied upon to achieve efficient performance, rather than emphasizing the definition of performance targets which themselves are taken to represent efficient performance. At least until very recently, there has been virtual neglect of possible market structure

strategies which would modify the physician-hospital relationship. It is to this class of strategies that I direct attention in what follows.

INSTILLING GREATER COST AWARENESS IN PHYSICIANS

This strategy is getting attention these days. In fact, it is getting a lot of attention. As I was coming out here on the plane, I was taking a look at the April 21 issue of *American Medical News* and was reading a featured story: “Medical Students Learn About Costs.” It pointed out that in quite a few medical schools, courses are being introduced on health care costs, the economics of the health care sector, and so on, for medical students.

The Connecticut State Medical Society and the Connecticut Hospital Association co-sponsor a series of seminars on physician-influenced costs of medical care. The seminars are regarded by Dr. Friedberg, Society president, as merely a first step, part of what will be a continuing active pursuit of “physician involvement and leadership in the continuing concern of all health professionals in the inherent problems of spiraling health costs.”⁹ Also, AMA Executive Vice President Dr. Sammons recently told the National Steering Committee of the Voluntary Cost Containment Program that instilling a greater awareness of costs in physicians-in-training “can play a major role in restraining future medical care costs.”¹⁰ I may note that, in cooperation with Blue Cross, the University of Oregon medical school is adding instruction in medical economics to its curriculum.

Along a related but somewhat different line, Dr. Roth recently made some suggestions deriving from his study “... to examine the performance of the average physician in his role as purchasing agent for his patient.”¹¹

Roth argued that the degree to which the physician may act responsibly in this area depends upon his knowledge of the prices of hospital services. He conjectured that not enough is being done to develop a sense of price consciousness in hospital staff physicians and he recommended to every hospital staff that such an educational project be included on the hospital’s program at appropriate intervals.

We should remark that with the first two programs alluded to, there is an implication, at least, that

⁸ See, for example, David S. Salkever and Thomas W. Bice, “Certificate-of-Need Legislation and Hospital Costs.” Also, Fred J. Hellinger, “An Empirical Analysis of Several Prospective Reimbursement Systems.” And, Bauer, previously cited. All appear in M. Zubkoff *et al*, *Hospital Cost Containment*.

⁹ *American Medical News*, February 13, 1978, p. 7.

¹⁰ *Ibid.*, March 29, 1978, p. 6.

¹¹ Russell B. Roth, M.D., “How Well Do You Spend Your Patients’ Dollars?”, *Prism*, September 1973.

physicians have a conscious obligation to "the hospital" or the "health care system" to attempt cost containment as they practice medicine.

It is an interesting and important question whether the physician can or should be expected to serve both his patient and some general social or institutional obligation. It is by no means clear that the answer to this question is affirmative. The physician-patient relationship features product uncertainty and information inequality such that patient "trust" of the physician is crucial to the relationship. The patient trusts the physician to give single-minded attention to his or her own welfare. A patient who had reason to suppose that his physician was managing his case with a weather eye to "the greatest good for the greatest number" (the general system-wide cost containment problem) no doubt would feel uneasy and might experience diminished trust of the therapeutic relationship. These considerations must be taken into account in the design of programs to harness physician behavior to general cost control objectives.

The Roth suggestion is of a rather different kind. Roth set about evaluating the performance of the physician *as a purchasing agent for his patient*. The extent to which and the way in which the physician's single-minded attention to the patient's welfare should include responsible discharge of a purchasing agent role may be debated. But at least the Roth approach to cost awareness is generally in line with the picture of the physician as the servant of his patient as distinguished from the deliberate, self-conscious servant of the general welfare as this turns on cost containment in the health care sector.

THE HOSPITAL MIGHT BILL THE PHYSICIAN FOR HOSPITAL SERVICES THE PHYSICIAN ORDERS FOR THE PATIENT

Programs to encourage physician awareness of hospital charges for services they order on behalf of their patients would appear to be easily accommodated. And they might have significant favorable impact.¹²

However, I think most people are of the view that at best this is probably not a very powerful cost

¹² Research should be undertaken to test this, perhaps in the form of a longitudinal study which would compare base period physician prescribing patterns by diagnosis with post-intervention patterns. The observations would need to be run long enough to avoid simply observing a Hawthorne effect.

I think somebody should do this if you can find a hospital with reasonably good records so that you can construct the base-period prescribing patterns. It shouldn't be too hard to run if you can find a medical staff that is willing to cooperate.

containment strategy. Consequently, a more fundamental structural reform warrants consideration. Such a reform would be an arrangement under which the hospital would bill the physician for hospital services he ordered on behalf of his patient. The physician would, in turn, recover the bill from his patient (and/or patient's insurer).¹³

Such a program would at least be more effective than the education programs discussed previously in establishing cost awareness in the physician. Beyond this, such an arrangement would encourage "cost responsibility" on the part of physicians, e.g., a sense of responsibility to explain to the patient the relative merits of alternative therapeutic regimens with their associated costs.

In evaluation of this arrangement, an important question concerns the extent to which it might alter other features of the current physician-hospital relationship, either for better or for worse. There is a danger of neglecting important features of a more dynamic and subtle kind in the physician-hospital relationship. As matters stand, one might characterize the physicians as *de facto* but not *de jure* "customers" of the hospitals. In part for this reason, their marketer role is ambiguous. And it is also ambiguous for the reason that, as professionals (and analogous, say, to the role of faculty in universities), the physicians regard themselves as "officers" of the institutions to which they admit. They thus legitimately share authority in the governance of the hospitals.

Under the arrangement proposed herein, the physicians' marketer role on the demand side of the market for hospital services is less ambiguous than under the conventional arrangement. For this reason, forces might be put in motion which would alter the role of physicians in the governance/management of hospitals—the relationship of shared authority as part of the "management triangle." For example, the greater cost consciousness entailed by the suggested arrangement might lead to physician pressure on administrators/trustees for greater efficiency—just the reverse of the situation with conventional cost-control strategies, which must assume administrator/trustee pressure on physicians for greater efficiency. This, by

¹³I have made this suggestion elsewhere. See "Hospital Costs: On Rationalizing the Physician-Hospital Relationship," *Inquiry*, September 1977.

the way, goes to some of the implications of what Professor Seidman had to say, because his suggestions with respect to cost sharing and financing would thrust upon the physicians incentives similar to those I suggested with respect to the modification in the physician-hospital relationship. Also, there is the possibility that the physicians would develop an interest in "shopping around" for hospital services—which would entail a wider access to hospital services for their patients than is available under conventional arrangements with restricted admitting privileges, and hence might lead to changes in these restrictions.

Strictly from a cost-control point of view, one might be inclined to regard physician pressure on administrators/trustees for efficiency and physician "shopping" for economical hospital services as pluses. On the other hand, such an open marketer role for the physician on the demand side of the market for hospital services might have untoward consequences because of the implied alteration in the physician role in the governance/management of hospitals.

According to this scenario, the physicians might, in effect, exchange their conventional mixed-mode role, as *de facto* customers who share authority in management, for what would be more frankly marketer roles as "consumer sovereigns." Of course, none of these consequences necessarily is entailed by the proposed arrangement.

CONSUMER COST SHARING AND PHYSICIAN AWARENESS OF COSTS: DO WE REALLY WANT THEM?

The impact of the change in the physician-hospital relationship to which attention is directed herein—that is, the change whereby the hospital will bill the physicians, who will recoup from their patients—would be enhanced if the patient and physician were under a health-care financing system which featured substantial consumer cost sharing, such that the physician's decisions to order hospital services would be important determinants of the potentially substantial out-of-pocket expense the patient might incur for the management of his episode of illness. The physician and the patient would be inclined rationally to explore the therapeutic and economic implications of the various choices.

Indeed, it might be argued that if there were cost sharing, the proposed arrangement itself would not be required, i.e., would add nothing. This is not the case, however. The proposed arrangement exposes the physician to some risk sharing on hospital services account which, under the conventional arrangement,

he passes to the hospital, whether or not there is consumer cost sharing.

To illuminate the incentive implications of this arrangement it is pertinent to note that physicians staffing comprehensive HMOs are, in effect, "charged" for hospital services they order on behalf of their patients. That is, *ceteris paribus*, the more revenue going to expensive, in-patient hospital services, the less will be available for physician compensation—an effect which would tend to yield economy in resorting to hospital services. We may call this effect the "capitation bias" against resort to hospital services. To some extent, the arrangement discussed herein can be regarded as a way to bootleg the "capitation bias" without resort to capitation. That is, under this arrangement, the physician is also "at risk" for hospital services in the sense that the less the physician bills on hospital services account, the more may reasonably be regarded as available to defray charges on physician services account.

It may be argued that the proposed arrangement would, if implemented, tend to harness the physician's attention to his patient's welfare, as this depends not only upon the effectiveness of treatment, but also upon the selection of economic treatment regimens—including utilization of hospital services—and would thus afford an appropriate, efficient solution to the hospital cost containment problem.

Although we cannot really engage the issue here, we should at least pause at this point to remark the possibility that, even though the foregoing "may be argued," it may also neglect important aspects of the reality of the physician role. After all, the conventional physician-hospital relationship, peculiar as it may be, has been around for a long time—a circumstance which would, *prima facie*, suggest that it may serve some legitimate, important function. But what is that function?

I think, generally speaking, when economists look out upon the world and see institutions that have been there since the Year One but which seem to them to make little sense, they initially should think to themselves, "Well, maybe I am missing something," rather than entertain the alternative position that everybody else has been missing the boat for fifty years. So I would emphasize that we need to take a close look at what legitimate functions may be served by the conventional physician-hospital relationship.

Harris has suggested one answer to this question. He regards the typical hospital as two firms—the hospital component as supplier of hospital services,

the medical staff as demander of hospital services—loosely connected by a complex set of *nonmarket* relations. In this setting, the physician is expected to do everything scientifically indicated for his patient without reference to price. This expectation is, in Harris's view, an ideological imperative of the physician-patient relationship. If this is valid, then the conventional physician-hospital relationship, which is so well designed to accommodate the physician's obligation, as it were, to avoid cost-of-treatment calculations, must be itself regarded as responsive to an ideological imperative of the physician-patient relationship. It is clear that deep questions are suggested by this line of argument.

Turning to the related market structure feature, it cannot be gainsaid that a health care financing system such as our present one, which features little or no consumer cost sharing for hospital services, has untoward implications for allocative efficiency. This point was made by Professor Seidman. Under such a system, consumers are not informed about the opportunity costs of their choices. Moreover, I am convinced that as long as we maintain the present kind of system for financing the demand for health care, the demands for ever-increasing regulation of the health care system and the hospital sector in particular will continue unabated.

Professor Seidman made that point. I tried some weeks ago to make that point very forcibly to a meeting of hospital administrators in San Francisco. I said, as long as you have first-dollar coverage, you are going to be regulated more and more. Hence, if you don't like regulation, you ought to be on the side of patient cost sharing. I evoked no response to that. And I didn't notice much response here to this proposition.

The reason for the demand for regulation is not that we know what the "right" (efficient) rates of resource allocation to the sector are and that the sector is not in compliance with this criterion. Rather, the reason for the demand for regulation is that, whatever the right rate of resource allocation to the sector may be, few are prepared to believe that a sector financed as this one is financed is likely to achieve that rate. It makes little difference in evaluating the success of a cost sharing system for financing demand whether it results in diminished utilization rates. The great advantage of operating under a cost sharing system would be that consumers, operating in their marketer roles, would validate (by their price-informed market behavior) whatever rate and pattern of resource allocation to the health sector emerged.¹⁴

Whatever the inefficiencies associated with, and possibly entailed by the present propensity for "first dollar" insurance coverage, we must entertain the possibility that the social order may prefer to accept this kind of inefficiency rather than to incur what it may regard as the yet greater social disutility entailed by resort to cost sharing and price rationing. A few words of explanation are in order on this.

Although consumers purchase many products on the installment plan (use now, pay later), they may prefer to purchase medical care on the reverse installment plan (pay now, use later). Fuchs, in remarking on the preference for "first-dollar" or "shallow" coverage comments: "I believe one reason is because people want an easy, convenient, systematic way of paying for medical care. It is a great mistake to view the purchase of health insurance as simply the result of a desire to avoid risk."¹⁵

These preferences might still be consistent with substantial cost sharing if consumers under cost sharing had access to an alternative, easy, convenient way of paying for medical care—say a state-operated program under which consumers had guaranteed borrowing rights to finance medical care *ex post* its consumption. But the propensity to "first-dollar" coverage may run deeper than mere concern over inability to finance demand for health care. That is, consumers may derive great utility from having the medical care choice structured in such a way that cost does not enter into it—such that this choice (with its peculiar, special nature) becomes, at the choice point, a "non-economic" choice. Informed consumers might be willing to pay a good bit on allocative efficiency account to achieve these utilities on structure-of-choice account.

It is hard to overstate the importance of mounting research seriously to engage the issue of whether consumer preferences conform to the pattern hypothesized above. If, in terms of fully informed consumer preferences, cost sharing is not acceptable, then the whole market structure planning approach may have to be abandoned and attention turned to ways in which to make alternatives more attractive.

¹⁴From this point of view, elaborate social experiments to determine the impact of cost sharing on utilization rates are beside the point.

¹⁵Victor R. Fuchs, *Who Shall Live?*, previously cited.

EMPLOYMENT-RELATED PLANS: SWEETENING THE CHOICE OF COST SHARING

How might we test the acceptability of cost sharing? Most of the coverage under private health insurance takes the form of employment-related plans. Consequently, it is reasonable to direct initial attention to this health insurance sector, i.e. the impact of cost sharing will be greatly attenuated if a strategy cannot be found to promote cost sharing in this sector. A number of tax system-related and organization-related reasons account for the seemingly "irrational" proclivity of employment-related plans to adopt shallow, first-dollar coverage. In light of these factors, it is unlikely that a proliferation of cost sharing in employment-related plans can be achieved by urging the parties to such plans to substitute cost sharing for first-dollar coverage. To choose cost sharing would appear to the employees tantamount to choosing a lower level of benefits than could be enjoyed by choosing the more expensive first-dollar coverage. The choice must be contrived to enhance the attractiveness of the cost sharing option.

A way to accomplish this would be for employers to offer their employees a choice as follows:

Plan I: A conventional, first-dollar coverage plan.

Plan II: A cost sharing plan, plus cash equal to the difference in premium cost between the first-dollar coverage plan and the cost sharing plan. Employees electing Plan II would be guaranteed participation in a loan program to help with financing out-of-pocket health care expenditures.¹⁶

An obvious problem with this strategy concerns the tax treatment of the cash payment under Plan II, and there may be some adverse risk selection problems to be attended to in setting the premiums for the two plans. Nevertheless, field trials of this strategy could serve as a sort of social experiment to test the acceptability of cost sharing. And this in turn will have an important bearing upon what modifications of the traditional physician-hospital relationship offer promise as a way to increase the efficiency of health sector performance.

¹⁶This scheme has been suggested by John Stryker, see *An Oregon Strategy for Containing Health Care Costs*, Portland, Applied Social Research, Inc., August 6, 1976.

The Health Services Agencies and Hospital Costs

JAMES KIMMEY

CHAIRMAN ANDERSON: The first speaker was an example of a pure economist. The second speaker was an example of trying to integrate economics, sociology and politics. The third speaker has no such ambiguities. He is a planner and a physician and has had a lot of experience in the public health field. Furthermore, he was one of the prime architects of the State of Wisconsin Health Planning Law and headed that planning division for some time.

Dr. James Kimmey is now the director of the Midwest Center for Health Planning, Inc., serving the midwestern states, and located in Madison, Wisconsin. He will give you some idea of the current boundaries in which hospitals are beginning to operate.

DR. JAMES KIMMEY: It is a pleasure to be here today. I very much enjoyed the first two papers, but I suspect that you will find my viewpoint is somewhat different as we will see as we go along.

I was reminded of the apocryphal story of three men who were sealed in a room with no doors, no windows, nothing, just four blank walls, a ceiling and a floor.

One was a health planner, one was a hospital administrator and one was an economist. They wanted very much to get out.

The hospital administrator looked at the administrative tools and the supplies available to them and concluded that it was impossible. The hospital planner did a complete analysis, articulated their goal, stated their objective, developed several recommended actions, but found that there were no resources. Finally the economist said, "Well, you guys failed, but I can get us out."

They said, "How? Four solid walls, a ceiling and a floor. How are you going to do it?"

He said, "First you assume a door."

I want to talk about health systems planning and hospital cost containment today, and ways in which these two things are already related, ways in which they could relate better, and perhaps some ways in which the relationship may not pay off for health planners or for hospitals or for those who pay the hospital bills.

I assume, in an audience of hospital administrators, particularly in an academic setting, that everyone is familiar with Public Law 93-641, the National Health Planning and Resources Development Act of 1974. Further, I don't think we have to review for this audience, perhaps for any audience any more, the details of the problem of cost in the health care field, and particularly the rapid rate of escalation of health care costs as compared to increases in costs in other portions of the economy. It is fairly well accepted now that health care costs are inflating at a rate faster than other parts of the economy. This has given rise to a great deal of academic interest, and political pressure, to find solutions, to "do something about the health care cost problem."

The problem of health care costs has, in turn, spawned a variety of proposed remedies for the situation. You have heard a couple of suggestions this morning. There are others that will be presented at this meeting, and I am sure most of you have run into still others in reading the literature and going to other meetings, which are increasingly focused on the health care cost problem.

I classify the proposed solutions in four or five large groups. I would like to offer a classification, and discuss a bit of the theory behind each group, some of the tools that will be required in order for the solutions being proposed to take effect, and some of the problems that we have in applying these various solutions to the cost containment issue.

The first classification that one ought to delimit in approaching cost containment is that of "laissez faire." Basically, the laissez faire proponents say, as you might expect, that government intervention, whether in terms of financing, or in terms of regulation, is all bad. Indeed, they feel it has contributed massively to the problem. The laissez faire solution to the problem would be to pull all governmental intervention out of the health care field. Then, the "invisible hand of competition" would begin to redress the imbalances of cost and problems of access which we are currently experiencing.

There are not very many pure laissez faire proponents around anymore. My father-in-law was one. He was a surgeon in a small town in Ohio. He used

to get up in the morning and walk over to the window and pull the curtains back, and it would be raining outside. He would say, "Goddam Franklin Delano Roosevelt!" That was in 1961, but you all know somebody like that, don't you?

You don't really hear the *laissez faire* attitude expressed much anymore. Even the most conservative of national organizations have recognized that the government cannot, any longer, completely withdraw from the health care field.

A second classification of solutions is put forth by those who would develop a health marketplace. The first two speakers this morning were certainly talking along these lines. The market theorists grant that there is a problem, a market problem, in the health care field as it is now structured. This is seen as the result of defects in the economic structure of the health industry which creates adverse incentives, and which interferes with normal market mechanisms. The recommended policy options of the market theorists are designed to create a market where none exists.

There are a variety of things that have been suggested: changes in the financing system, as discussed this morning; changes in the structure of health services delivery, as for example the federal push to promote the health maintenance organization alternative to the fee-for-service system; and creation of community care organizations, which is a less structured HMO-type approach. I think you will probably hear more about these in the course of this two-day conference as well.

The market theorists have a lot going for them in terms of the basis for their arguments in economics. Their arguments strike responsive chords in almost anybody in the United States as they talk about creating competition, about the virtues of free enterprise, and all the other good things that come with the market solution.

I think that we will see experimentation, as was suggested this morning, with several different market solutions in the health care field. The question, of course, is: Can the results of those experiments come soon enough to convince any policymakers to turn back from the current course. I suggest that they may not, and that we are entering a period in which current policies will continue and be expanded while the experimentation of the marketplace goes forward. We are going to reach a point where we will have to decide whether to turn back from current policy and pursue the marketplace solutions, or to go full-fledged in the direction in which we are now going.

A third group of solutions, and probably the newest group offering approaches to the cost containment problem, can be classified as the life style approaches. The life style approach is a particularly interesting one. It has grown up and gained currency in the last two or three years, largely on the basis of a document called "A New Perspective on the Health of Canadians." This report suggests that problems in the costs of health care, in accessibility and the excess demand in the system is not the result of anything that is wrong with the system per se, but rather the way people treat their bodies, and the low regard in which they hold positive health. It suggests that a series of governmental and private actions to improve life styles, to cut down on the environmental causes of disease, to get people to change their habits in terms of smoking, eating, exercise, etc., is really the correct way to go in the long run to gain some control over the burgeoning health care delivery system.

As a public health physician, I cannot help but admire this approach and feel that it has a role, but that it is not an answer. I believe that we have seen, in at least some health system agencies around the country, life style type programs which have diverted these agencies from other things that probably ought to be done first to affect the short-run course of cost containment.

That brings us to the fourth solution classification, the regulatory solution. I am sure almost everybody in the room is familiar with the general attitude of those who feel regulation of the health care delivery system is the only realistic approach to cost containment.

Picking up on the last speaker's remark that the regulators are winning, indeed I would submit that they are not only winning, they have already won. The questions are: How much regulation is there going to be? How broad will it be? And how much is it going to be utilized in terms of promoting other alternatives within the system?

When the Congress passes legislation which mandates that every state pass a certificate-of-need law meeting federal requirements; when the Congress considers seriously, recertification legislation; and when the Congress reports out cost containment bills that include temporary revenue controls (when was the last time you saw a temporary regulation?); I think that one can fairly say that if regulation hasn't won, it is way out in front of all the other alternatives that have been put forward.

Public Law 93-641, with mandatory certificate-of-need and appropriateness review, has been, to date, the

major vehicle at the federal level in laying the groundwork for a regulatory solution to the cost problem. It is interesting that it should happen this way, because, if you sketch the history of health planning over the past several years, it has not been a regulatory mechanism in its previous incarnations. The tight ties between the health planning process and the regulatory process that have been incorporated in P.L. 93-641 are clearly different from the way that some of the certificate-of-need programs were conducted in the past, relatively independent from the planning structure.

The focus of P.L. 93-641 is very much on the health care institution. The federal certificate-of-need regulations that define the approach that a state must adopt, refer to planning for health care facilities, including hospitals, psychiatric hospitals, tuberculosis hospitals, and so forth. Little in the mandatory portion of the Act attempts to regulate other health care settings. Under this legislation, the planning process must take into consideration the allocation of resources affecting ambulatory settings and so forth; but on the regulatory side, the law focuses very clearly on the institution. More particularly, it focuses on regulation of capital investment through certificate-of-need legislation.

There are many reasons for this focus. One is that capital investment does make a contribution to the per diem proportion of an institution. Probably more basic to the emphasis on regulating capital investment is the contribution that new facilities and services make to operating costs over time. Finally, the perceived duplication of services within the system is at issue. All of these concerns have combined to make attractive to Congress the idea of a certificate-of-need program as a national policy, and the majority of states have responded by enacting certificate-of-need laws.

There are a number of defects in the certificate-of-need structure mandated under P.L. 93-641. First, of course, and probably most prominent is the lack of capital expenditure control in non-institutional settings. State certificate-of-need laws that have been enacted to comply with the Act focus on equipment, beds, and so forth, in institutional settings, disregarding the location of the same equipment in non-institutional settings—clinics, health maintenance organizations, physicians' offices.

Probably the classic example now used by everybody that lectures on this topic, is the CAT scanner. Cases have occurred in which CAT scanners that were not justifiable in the institutional setting have

been placed in an office setting, or even in leased space in the institution. This latter ploy avoids the certificate-of-need law but very neatly puts the service where it was desired in the first instance. Actually, those who have done this have provided a great service to those who regulate the system. I would submit that the CAT scanner has done more to promote health care regulation in the United States than any other single innovation or change in the last 10 or 15 years.

In Wisconsin four years ago, it was proposed to extend certificate-of-need coverage to equipment in physicians' offices. The proposal got nowhere. Last year Wisconsin enacted a certificate-of-need law that extended coverage to items of expensive equipment, regardless of their setting. The difference was that the Medical Society, after the bad press of CAT scanner acquisition in the state, endorsed coverage of equipment in certain non-institutional settings. Approximately eight states now have such coverage, and under pending legislation at the federal level all states would be required to extend coverage of certificate-of-need to non-institutional settings for some types of equipment.

A second potential defect which was not a part of the original legislation, but is part of amendments, is the virtual exclusion of health maintenance organizations from review whether for inpatient services or outpatient services.

In the testimony in front of the House and Senate Committees considering continuation legislation, the group health association and individual HMOs have made a very persuasive case that HSAs and the health planning and development structure are anti-HMO because they have consistently decided against alternative delivery systems, and they are dominated by conventional provider interests (whether institutional or individual providers). Therefore, if the administration and Congress really want an HMO alternative to develop, HMOs ought to be excluded from regulation. It looks right now as if HMOs will be essentially excluded in the new federal guidance for state certificate-of-need laws.

Another defect in certificate-of-need as introduced in P.L. 93-641 is the lack of firm ties to rate regulation programs. P.L. 93-641 did provide for six demonstration rate review programs, but they were not required to be tied to the certificate-of-need programs. States which have rate commissions that are independent from those administering certificates-of-need experi-

ence a certain amount of non-creative tension that results from these two kinds of regulatory activities being conducted in different agencies with different goals and different actors.

Let us examine for a minute how the health systems agency, the state health planning and development agency, and other organizations fit into the regulatory process. I won't spend a lot of time on it, but I think that since it was in my title, it ought to be touched upon.

The basic structure for review under a mandatory certificate-of-need law vests the regulatory authority, the decision-making authority, in state government. The decision as to whether a certificate should be granted or not granted is left to the state governmental agency involved. The health systems agencies, 90% of which are private non-profit corporations at this point in time, are in the position of reviewing and recommending whether or not the state should offer the certificate or not, but they are not the regulatory body. This is a very important point, both because some HSAs don't recognize it, and secondly, because it might be counterproductive for the HSA actually to be the regulatory decision maker in certificate-of-need actions. True, the structure is built in such a way that there are opportunities for the HSA as well as for the proponent of a project to appeal a decision of the state agency, but the HSA itself is a recommending agency.

Under the certificate-of-need laws, as they are required in relation to P.L. 93-641, the HSA and the state are strictly in a reactive negative posture. The projects are generated by institutions. They come to the process for a yes or no decision. This is a major weakness. The better HSAs are trying to find ways to relate better to institutions in the long-range planning process, and in the application preparation process. This insures that they don't always end up in the position of recommending only a yes or a no on an individual project, but rather participate more fully in the process of project development in the community ahead of time.

The HSA's recommendations and the state agency's decisions are to be based on standards and criteria published in advance and made available for those applying for approval. These are, in turn, to be based on the plans produced at the community level and the state level, the health systems plans and the state health plans. The planning function of the HSA is to be the basis for its review function. The planning function at the state level is to be the basis for decision making.

You understand, of course, that I am talking strictly

in the ideal and abstract at this point. To those of you from New York who know that the way to get obstetrical beds is to talk to the governor, I will have to admit that there is a certain amount of politics that enters into the regulatory process as it is currently structured. I don't know how many know the story. I don't know whether to put it as a positive or a negative story. From some people's perspective it is very positive. From others' it is negative. The Finger Lakes Health Systems Agency in New York worked long and hard, both as an HSA and a B agency, to merge some obstetrical units in the Southern part of their region. They finally succeeded. The governor came to town three days later, after everyone had agreed to the merger, and someone raised the question after a speech. He essentially said, "You don't have to worry about that. You can all have your obstetric units. Everybody should have a choice," and that was it. They all had their obstetric units and fifteen years of planning went out the window.

In Massachusetts, the devil is the legislature rather than the governor. There, if you fail to get a certificate-of-need and you have political clout, you can go to the legislature and get a special bill for the relief of St. Swithen's Hospital, and you end up with a certificate.

The federal government is now trying to close that loophole with legislation, and both the Senate and the House have now included language that says that the certificate has to be issued through an administrative process. That would preclude legislative review. I suspect that the Supreme Court will have something to say about that at some point in the future.

One other point that hospitals have been made very aware of is the role of the national guidelines for health planning. As most of you know, I am sure, Secretary of Health Califano has published as rules, therefore having the force of law, a set of guidelines for acute care services, obstetrics, pediatrics, CAT scanners, therapeutic radiology, neonatal intensive care, cardiac surgery, cardiac cath and so forth. The Department has issued guidelines which HSAs are expected to incorporate into their plans and also incorporate in their review processes.

The initial issuance of these guidelines was roundly attacked. Thousands of letters descended on the Department as a result of the first publication of guidelines. The vast majority of the letters were directed at the concerns of rural hospitals, concerns about the effect of the application of inflexible occupancy rates and inflexible beds per thousand rates in rural communities. As a result of this public outcry

the Secretary did soften his position in reissued guidelines. It is now possible for an HSA to adjust the guideline for a specific area or part of its area under certain circumstances.

My personal opinion is that the new guidelines are not nearly as flexible as they seem since the adjusted figures are still subject to approval at the state level. The amount of information required for an adjustment is very extensive, and may decrease the number of adjustments used. However, we will see how this washes out in the future in the development of health systems plans and also in the development of recommendations on specific projects.

Having mentioned that the governors have interfered in the process, and that the legislature in at least one state has done so, we can't forget the judicial branch. A lot of certificate-of-need decisions these days in many states are being made in the courts. Perhaps this is one of the problems you meet when you get into an administrative regulatory type of structure, but on whether or not this is a full employment program for hospital lawyers and external consultants (both of whom seem to be doing very well under the certificate-of-need law as it is now written), I guess I will reserve judgment.

There are some problems with the program in practice as well as in theory; one is that there probably is too much "yes." If you look at the results of the certificate-of-need programs today, there are relatively few turndowns. Now this could reflect the fact that agencies are working effectively with institutions in advance of submitting projects, and that is what I think everyone would like to believe. It also could speak to the fact that the criteria and standards being applied and the ways in which they are applied, are not yet very accurate. They often can't stand administrative review. They often don't stand up in court.

The second problem is that the certificate-of-need focuses on "new." If you don't intend to do anything, if you don't intend to change anything over time, it doesn't affect you. Until you come in with a request for a certificate, there is no way that the regulator can really look in a structured fashion at what exists and what is, with any degree of assurance.

Of course, an attempt was made to get at this through recertification requirements under earlier proposed legislation. They were knocked out largely at the behest of institutions and institutional lenders who said that if a hospital was at risk for its entire mix of services every five years, they couldn't get a reasonable interest rate. Institutions would be unable to borrow

money, and construction would virtually cease. There were those who thought that it was a good idea at the time, but it was beaten down. Recertification became appropriateness review. Now you may not have heard much of appropriateness review since it has been fallow for three years while regulations are written. However, the appropriateness review regulations will be out soon, and you will learn to know and love it just as you love certificate-of-need. I don't want to spend too much time on appropriateness review because it is very sketchy and the regulations may change.

Looking at the HSA role behind certificate-of-need, let me say a couple of things. The first area in which a role has been sketched out for the HSA that goes beyond certificate-of-need is in the cost containment legislation. In the original administration bill introduced last summer, which included both revenue control and a capital expenditure cap, the HSA was given a number of roles in each program. In most of the revisions of those proposals that have come out of the House and Senate Committees, the HSA also has a central role. Under revenue control measures which establish a percentage cap on revenue, the HSA's role is informational. The HSA would be given the responsibility for collecting information on charges from the institutions in its area, not only for per diem charges, but also charges for a selected group of ten major services. It would prepare summaries of charges to be distributed to the public, such summaries to be easily understandable.

They also were to review capital expenditures as they do now under certificate-of-need. If an institution proposed to go over the cap, the institution had to demonstrate that the service generating the excess cost had been found appropriate by the HSA. Of course, that would vest appropriateness review with a great deal of authority and importance from an institutional standpoint as well as from an HSA standpoint.

The third interesting role of the HSA was to act for the Secretary in investigating complaints that institutions were dumping low-pay or non-pay patients in order to stay under the cap. If one institution rats on another, the HSA does the investigation.

Probably of more importance because it is more likely to survive and become law, is the capital expenditure capping that was proposed in the cost containment bill. Under that legislation a \$2.5 billion cap would be applied nationally and redivided among

the states on the basis of population. Then, in issuing a certificate-of-need, the state agency would have to put a face value on each certificate. When the total of face values of certificates issued in a year reached a state's share of the cap, no more certificates could be issued. Also, if a health service area had more than four beds per thousand or less than 80% occupancy, no certificates could be issued at all, without regard to their face value, unless you closed two beds for every bed that was being certified.

Some of these provisions have been incorporated in continuation legislation for P.L. 93-641 and others are still very much a part of the cost containment bills as they are currently being considered in Congress. The focus, however, is still on beds. There is no focus here on services or institutional setting.

Another program, which I want to mention because the HSA has no role in it, is the voluntary cost containment program being proposed by the American Medical Association, the American Hospital Association and the Federation of American Hospitals. Since I am talking regulation, I mention this because I classify this as a straight regulatory program. It is non-governmental regulation but it is a regulatory program, nonetheless.

As you are aware, under that program, the three sponsors put together a national level coordinating body. Then they divide up and set up state committees to encourage institutions to direct their activities toward two goals: to decrease the rate of increase of costs by 2%, and to decrease the rate of capital investment in the system by 20% in the next year. Can you imagine what is going to happen if there really is a 2% decrease in the rate of increase in health care costs next year? Can you see the rush of people taking credit? PSRO did it, right? No, the voluntary cost containment program did it. No, the certificate-of-need did it. There will be a huge rush of people taking credit for it if, indeed, it can happen. The voluntary cost containment program is basically a regulatory approach. It has the shortcoming that institutions can opt out of it at any time, and short term gains which might turn aside federal cost containment legislation for a time may be offset by recouping the losses of those years in future years if the program remains voluntary.

In a way, success in the voluntary cost containment program will damn the program itself. If I were a politician involved in this, and indeed a voluntary effort held down costs at a rate of increase of 2%, the first question I would ask is: Why not the year before,

and the year before that and the year before that? If you can do it now, why couldn't you do it before? I think some of those nasty kinds of questions are going to be asked of the program, if, indeed, it is successful.

However, I think it is an important program for the very reason that it represents a relatively high degree of cooperation among physicians and hospitals in a way in which they have not cooperated in the past. At least in theory, it offers an opportunity for these groups to work together on cost containment strategies. Whether this would really happen in practice in a decentralized multi-state program remains to be seen, but I think it is a valuable initiative. I am not optimistic about its ability to offset either cost containment legislation or more stringent certificate-of-need programs for a very significant period of time.

Well, just a couple of other comments, and then I will quit and take any questions that might come up.

I would say that currently there is a community of interest sometimes at an HSA level, sometimes at the individual community, and certainly at the national level in containing health care costs. There is substantial disagreement about the methods that ought to be used.

At this point in time, at least, Congress has put the HSA and the state agency in a very central position in trying to develop cost containment programs and to implement them.

I would suggest that it is very much in the interest of hospitals to support this structure and this effort. I suggest this because despite the fact that there are national guidelines and federal provisions for how certificate-of-need programs ought to look, it still is by-and-large a non-governmental program. It is based in the private sector, and most of the HSAs are nonprofit corporations. The majority of the members of the boards are not representative of government at any level, and they still have some degree of flexibility in applying the various guidelines to particular situations at the local level.

The alternative to this, the Social Security District Office approach to health planning and regulation, is not something suggested only to frighten you. It is inevitable, if we cannot at this point in time, or in the next couple of years, make some progress using the HSA voluntary agency approach to carrying out these programs.

I offer as evidence the problems that PSRO is suffering in terms of budget and finance. As many of you know, the Office of Management and Budget defunded the PSRO Program and Secretary Califano

had to go on appeal to get the program re-funded for one more year. Health planners have been told several times recently by representatives of the Department that the PSRO experience should be watched by health planners because they feel the same way essentially about the health planning structure. If it doesn't produce in the next couple of years, the Department is not going to ask for money for it, much less will the Congress continue to support it. So regulation may be unpalatable, it may be difficult to live with, but I think it is very much a part of the picture, at least, in the short run.

The problem we face is limiting the expansion of

DISCUSSION

with James Kimmey

CHAIRMAN ANDERSON: Are there questions?

MR. DAVID M. HATFIELD: Dr. Kimmey, two points. One, would you comment on the government reaction to the effort of some groups of hospitals or multi-hospital systems to get lower bids establishing large group purchasing across the nation; that is, the government's turning around and saying you will get price fixing, or antitrust, or don't do it. It is bad.

The second point is the involvement in the future of VA hospitals in HSA planning.

DR. KIMMEY: On the first one, what can I say? It is a shortsighted policy on the part of the government to invoke antitrust in shared service types of arrangements.

In the case of the voluntary program, as probably you know, the sponsors have gone to the Department of Justice and asked for determination in advance that this wouldn't be found in violation of antitrust and restraint of trade if they attempted to implement a program that would reduce costs.

Those kinds of decisions that say group purchasing arrangements are in restraint of trade, are the kinds of decisions, I think, that can be overturned by legislation if you can get a determination by the Department of Justice or by the courts that changes the basis for them.

I think it is shortsighted. I don't know whose responsibility it is going to be to try to get that changed, but certainly that is a demonstrated saving area that ought to be promoted.

The second one, the involvement in the future of VA hospitals, is a continuing problem for health systems

regulation and looking for ways to utilize the regulatory authorities that are on the books in a creative fashion, to allow experimentation with some of the ideas moving toward a market solution, and to advance some of the ideas that underlie the solution recommended by the life style approach. Regulation, although it may look all bad if you have a particular project in mind, has some potential, at least, for being limited and used in a creative fashion, and I hope that we are intelligent enough to do that in this country.

planners because everyone has the feeling that somehow VA hospitals ought to be brought into the system and considered a part of it and be reviewed and so forth.

On the other hand, at the legislative level, the committee that is responsible for developing P.L. 93-641 and related legislation does not have responsibility for the Veterans Administration. They can only say, as they have in the congressional reports accompanying the legislation in the past, that they hope the committees with the responsibility for the Department of Defense and the VA will bring their requirements into line with the overall health planning structure.

It is of interest that, in promulgating the national guidelines and standards, the Secretary included as mandatory that every HSA has to undertake an adjustment to reflect the impact of the Department of Defense and VA facilities in the health service area. I think that even though there is no direct regulatory implication in this, it is very important, because for the first time HSA is mandated to look at the impact of VA and DOD facilities. One suspects that the VA is going to be required to provide the data and so forth, and so I think we are going to get a much better picture of the impact of the VA facilities on individual health service areas than has been the case in the past.

The requirements for the national guidelines have provided a spur to a very desirable planning process as it relates to the VA.

MR. MICHAEL MCKEE: I would like to ask if you could expand on the question of restraint of trade. It appears to me that there are three areas of restraint of

trade that could be of major significance to groups that are costly to hospitals. One of them is the idea, such as in Minneapolis, where we have an intermediary that bargains with nursing or other groups for the wage-type situation. Now, given the fact that labor is a major cost factor in health care and the hospital industry, that is a significant area where restraint of trade hindrances on the hospital industry at the bargaining table could have a serious implication.

The second area is in rate setting. Voluntary rate review organizations have cropped up all over the country. Here again there is a need to look at the antitrust implication of that, and then of course, the ability of the voluntary efforts to effectively contain costs.

The third area that is also important to look at for implications from the antitrust point of view is clinical shared services where cost savings are possible. Look at groups like the ones in Boston or Hartford where they get together and negotiate for which hospital is going to be the primary hospital for neonatal or psychiatric services or whatever. I wish that you would comment on them and their implications.

DR. KIMMEY: You know, I never like to duck questions, but I am not an attorney nor am I a hospital administrator. I am not really engaged in those kinds of issues all the time.

I think you are right that these are areas that require a more organized study, perhaps by higher level organizations either in the congressional context or in HEW or in the hospital context at the national level, to try and clear up those issues, but I am not really qualified to comment on them.

MR. ROBERT C. HARDY: I am glad you recognize that politics sometimes enters into certificate-of-need.

I am from Oklahoma, and I am informed that Oral Roberts was approved for his hospital. Now Oklahoma runs a 63% occupancy and 3,000 more beds than it needs, and yet this hospital, according to Oral Roberts, is mandated by God. How does P.L. 93-641 propose to close that kind of a loophole?

DR. KIMMEY: I will defer to a higher authority.

MS. LEA RESNICK: I would like to ask about the consideration given in general to public institutions, a small p, run by another body, in connection with an HSA for example, that is determining certificate-of-need.

How far can you go in exerting any influence on the public institution that is governed by another body in connection with their requirements?

DR. KIMMEY: You know, in theory again, the certificate-of-need law that a state has to pass and has to be implemented by the HSA and the state agency must apply equally to public and private institutions. In practice again, you get into the problem of God and government. Neither wants to be interfered with by something as temporal as an HSA, and so quite often you see HSAs having a great deal of difficulty dealing with the public sector institution.

This seems to occur more often where the HSA itself is a part of the same governmental structure. In practice, certainly the pressures that are brought on the HSA sometimes by the public institutions in various ways even exceed those brought by the private institutions which are often excessive.

The Experience of Blue Cross of Western Pennsylvania with Industry and Labor as to Cost Containment

HOWARD GINDELE

Mr. Richard W. Foster, Associate Director, Graduate Program in Hospital Administration and Associate Director-Administration, Center for Health Administration Studies, University of Chicago, presided over the second session.

CHAIRMAN RICHARD W. FOSTER: It has been alleged that the first step in solving a problem is to define it properly. If that is true, I think the first two speakers this morning got us off to a good start.

This afternoon's program at least initially was envisioned as really a continuation of a segment of the program that was started by Dr. Kimmey's talk this morning, namely, the presentation of a series of alternative approaches to dealing with problems which are essentially external in nature to the hospital. On the other hand, the first two speakers went beyond the simple definition of the problem and presented some proposals for dealing with the difficulties, and obviously there is some overlap here.

I am sure that even though we envision tomorrow morning's segment of the program as focusing primarily on matters internal to the hospital, those matters will come up to some extent in this afternoon's session as well.

I am very pleased to introduce our first speaker. Mr. Howard Gindele is President of the Blue Cross Association of Western Pennsylvania, and in light of all of the discussion that we have had earlier in the morning about employers and employees, Mr. Gindele is quite experienced and knowledgeable about how that relationship works. We are very pleased to have him tell us a little bit of what he knows about it.

MR. HOWARD GINDELE: I must say first that I am overwhelmed to be here today at your Twentieth Annual Symposium to discuss the experience of our Blue Cross Plan in Western Pennsylvania and how we are approaching the renewed interest in health care cost containment.

I realize that this portion of the program is to deal

primarily with industry and labor, and I think it only fair at the outset to indicate my intention of dealing with the subject of cost containment in a somewhat broader context. Industry and labor do, of course, play an important role in the financing of health care as well as in the containment of health care costs. But I think it must be understood that these two segments of our society cannot be isolated from the total community in discussing this vital problem—no more so in fact than doctors can be separated from hospitals, or health systems agencies from the general public. It is for this reason that I entitled this paper "Cost Containment: Everyone's Business; Everyone's Labor."

Notwithstanding the seriousness of the problem and the difficulties involved in reducing the rate of increase in health care costs to more acceptable levels, I am optimistic that our health care system can meet the challenge of Congressman Rostenkowski: that by all elements of the system working together we can succeed in keeping the health care system of this nation on a voluntary basis.

Before I try to substantiate my optimism, I want to take a few moments to establish my credentials. My employer, Blue Cross of Western Pennsylvania, is presently observing its fortieth anniversary. For thirty-four of these years I have served the corporation in various marketing and executive capacities. There is probably no major business or labor organization in Western Pennsylvania with which I have not had some contact over the years. For a substantial period of time it was my responsibility to serve as the chief Blue Cross representative nationally with the steel industry during their industry-wide negotiations. I am no stranger to the attitudes of both business and labor with regard to health care.

Our corporation serves a twenty-nine county area, geographically about half of the state. Much of this area is heavily industrialized, but it also includes a number of sparsely populated rural counties. About 4.3 million people reside in this area, and about 2.6 million, or nearly 60%, are Blue Cross subscribers. It should also be noted that little or no increase in the population of Western Pennsylvania is anticipated in

the next ten years. The population is an aging one. Based on the latest census figures, Pennsylvania has a considerably higher median age than the national average. In fact, only Florida, with its hundreds of thousands of retirees, has an older population in terms of median age than Pennsylvania.

The metropolitan Pittsburgh area has the fourth largest concentration of national corporation headquarters in the country. Similarly, it is a strong labor center, with the international headquarters of the United Steelworkers of America located in the heart of Pittsburgh. With this background, it is not surprising that there has been continuous pressure over the years for increased health care benefits, usually emanating from long and difficult labor-management negotiations.

The health care benefit programs that have evolved from these negotiations have strongly influenced the type of coverage offered by our Plan to all segments of the community. We believe that the kind of coverage we provide is the kind that can best meet the needs of the people of Western Pennsylvania and yet with every effort we could make, is structured to help contain health care costs, partially through the offering of a broad range of other than inpatient services.

We are proud of the fact that the first nationwide uniform service benefit agreement was developed in Western Pennsylvania in 1949 for the steel industry. We believe this agreement was truly a pacesetter for the entire country.

I said earlier that I was optimistic about a voluntary solution to increasing health care costs. Let me offer one specific reason for the way I feel. Despite the characteristics of the area, i.e. the heavy concentration of business and industry and an aging population, and despite the extensiveness of available health care benefit programs, we have in our area one of the lowest costs per day for hospital care of any heavily industrialized section of the nation.

In 1976, the latest year for which national figures are available, the average cost per patient day in Western Pennsylvania hospitals was \$155.16. This was \$9.33 less than the Pennsylvania average, and \$17.00 less than the national average.

In citing these statistics, I think it is important to note that this low per diem cost record did not come about accidentally. If I were to single out one cause it would be the historical record of cooperation among hospitals, physicians, and Blue Cross, with some strong support for this cooperation from the general community.

From the very beginning it has been the basic philosophy of Western Pennsylvania community leaders, both within and outside the health care industry, that working together would produce more good for the people of the area than assuming adversary roles. It is within this framework of cooperative effort that I feel qualified to discuss with you today what our Plan has tried to do to make health care available at the lowest possible cost and how this endeavor has involved all segments of the community including industry and labor.

Let me reemphasize the fact of total community cooperation. Back in the 1950s, the board of directors of our Blue Cross Plan requested that the Pennsylvania Economy League, a nonprofit research agency supported largely by business and industry, examine and evaluate our functions and activities, and recommend courses of action which might be pursued in order to more fully meet our community responsibilities. One of the conclusions reported by the Pennsylvania Economy League was: "Conferences with civic leaders and management and labor leaders; examination of financial and service records; review of publications and newspapers—all lead inescapably to the conclusion that Blue Cross is one of the most important community agencies in Western Pennsylvania. No other nongovernmental community agency approaches Blue Cross when measured in terms of direct service and financial responsibility."

Now I urge you to accept this statement not as a commercial for Blue Cross but as part of an important analysis of our corporation specifically designed to help guide the future actions of industry and labor members on the board.

The Pennsylvania Economy League also endorsed the corporation's cost containment objectives and the non-adversary role under which these objectives were being pursued. In accepting the report, our board of directors committed the corporation to more intensified cost containment activities and reinforced the concept that the corporation's commitment to cost containment should include a philosophical, financial, and manpower commitment. Accordingly, we have, to the extent we could, allocated the necessary human, technological, and financial resources in our cost containment efforts, and we believe that the payoff is measurable.

In the early 1960s, our board of directors committed the corporation to its first direct financial subsidy of provider support programs to the extent of \$200,000 annually. Last year the Plan's subsidy to health care

organizations as measured in terms of manpower expenditures and cash outlays, amounted to more than \$550,000. Direct financial assistance, plus the value of computer services and manpower costs, exceeds \$10 million over the past twelve years.

A recent action by the cost containment committee of our board of directors further demonstrates the corporation's current interest and commitment to help in every way possible in holding down health care costs. Membership on this board committee, by the way, is made up of representatives of business and industry, labor and health care providers. As recommended by the cost containment committee, the corporation has established a \$1 million revolving cost containment fund through which repayable interest-free seed money is available to Western Pennsylvania hospitals for any approved cost containment program. The first use of monies from this fund will be devoted to an energy conservation program. This effort will be in conjunction with The Hospital Council which, in cooperation with the University of Pittsburgh, developed the original framework for an energy conservation program. It is conservatively estimated that through this program our hospitals will be able to achieve annual savings of \$3.5 million.

As far back as 1958 we began working with health care providers to establish hospital utilization review committees, in order to identify and analyze factors that could contribute to unnecessary or ineffective use of inpatient services and facilities. The booklet we published in 1958 on this subject generated national interest. As a result of this activity, nearly all hospitals in Western Pennsylvania had utilization review committees in operation prior to the Medicare requirement in 1966.

Also in 1958, twenty years ago, we undertook a joint program with our local councilor district of the Pennsylvania Medical Society, and again with our local Hospital Council, to help educate physicians in the appropriate use of inpatient facilities. A claims review procedure was established under which questionable cases such as inpatient diagnostic admissions, or inappropriate lengths of stay, were referred back to the hospital utilization review committees for further study and advice.

At the same time, and again in conjunction with the Medical Society and Hospital Council, a Medical Advisory Committee was established to resolve differences of opinion between providers and Blue Cross concerning individual cases. This committee has been meeting weekly now for twenty years, and more

than 50,000 cases have been reviewed during that time.

Another one of our early activities was participation in the establishment of the Hospital Utilization Project (HUP), a program which provides hospitals with valuable data on comparative utilization patterns such as length-of-stay reports by major diagnostic categories; selective comparisons among hospitals of similar size, setting, services, and staffing; and periodic profiles for individual hospitals indicating major diagnoses worthy of special utilization review committee attention. These data enable each hospital to measure its performance against peer hospitals.

We provided technical assistance, staff, and data processing facilities during HUP's formative period, and continue to assist through review and control services. In all, the corporation's contribution to HUP, including staff time, facilities and direct funding, exceeds \$1 million.

The concept of area-wide planning of health care facilities took root in Western Pennsylvania back in 1960 with the formation of the Hospital Planning Association. This association laid the groundwork for the Comprehensive Health Planning Agency when that federal organization came into being in the late 1960s, and continued its planning activities until superseded by the present Health Systems Agency several years ago. Since 1960, our corporation has been actively involved in hospital planning both in terms of manpower and financial support. Currently, several of our management people serve on local HSA boards and subcommittees. We strongly feel that proposals for additional health care facilities or equipment, along with their attendant costs, must be closely evaluated on the basis of total community needs and the ability of the community to absorb the costs.

We are doing everything possible to help assure that health care planning succeeds. Last year we were successful in gaining approval for a moratorium on CAT scanner purchases in the ten-county district served by our Pittsburgh-based Health Systems Agency. This moratorium hopefully will remain in effect until quantitative and qualitative guidelines are established that will conform with HEW's national standards.

Several years ago we assisted our Hospital Council in the establishment of a group purchasing program developed to help hospitals purchase goods and

services at the lowest possible cost. Western Pennsylvania hospitals now realize a savings of approximately \$7 million a year from this program.

One of our most important projects is a hospital computer sharing system which processes hospital administrative information. This system began operations in September 1969, and is offered to all hospitals in our area. At the present time, twenty-eight hospitals are using the total system capabilities and twenty-two others make partial use of available services.

The shared computer system assures these hospitals all the advantages of a large-scale computer, but eliminates the need for each hospital to invest the time, money and staff necessary to acquire and operate its own computer. Substantial cost savings are inherent in a program of this scope which offers faster and more efficient operation and at the same time eliminates unnecessary duplication of computer facilities. The system is currently producing savings of more than \$800,000 per year over similar shared programs, and more than \$1.4 million a year compared to a proliferation of multiple in-house computer systems.

Our research department and our management services consulting department are working with hospitals continually in the development of improved management methods, programs for sharing of services, and many other such cooperative efforts designed to increase efficiency and economy in hospital operations. The management consulting services program is carried out by Blue Cross staff and is regularly available to all our hospitals. This program employs industrial engineering and management techniques to increase the effectiveness of hospital operations. So far, it has produced measurable savings of \$13 million in hospitals using its services.

The method we use to reimburse hospitals represents another important element in our cost containment effort. In 1973 we signed a new contract with hospitals after long and difficult negotiations extending over a three-year period. During the negotiations both sides were interested in exploring improved concepts of reimbursement as well as ways to improve patient care. During negotiations, both we and the hospitals were kept acutely aware of the need to negotiate an agreement that would produce the most economical delivery of service. Our reimbursement contract offers hospitals a choice of traditional retroactive reimbursement method and a newer prospective budget method.

The prospective budget reimbursement method

projects "cost of care" figures in advance for a twelve-month period, in contrast to the more traditional reimbursement methods under which hospitals are paid after the fact for costs incurred in providing patient care. We presently have twenty-one hospitals participating in the prospective budget reimbursement program, and we continue emphasizing this method where it appears appropriate.

The program as it developed in Western Pennsylvania was first applied experimentally over a three-year period (1971-1973) at five small community hospitals. It helped moderate cost increases at these hospitals over the three-year period and produced a savings to Blue Cross of \$180,000 and a total savings to the community of \$360,000. Extension of this program to more hospitals has to date generated savings to Blue Cross subscribers of more than \$11 million, and cumulative savings to the community of more than \$37 million.

These are but a few of the examples of cost containment activities in which we are involved. There are others, of course, carried out on a day-to-day basis. But reviewing again just those that I have mentioned and isolating the specific activities to which dollar savings can be accurately ascribed, we get a reasonably clear picture of the value derived from the \$10 million invested by our corporation over the past twelve years.

1. Our program of utilization review activities obviously has produced large savings. It is difficult to accurately put a dollar amount on these activities but certainly \$2 million a year would be extremely conservative. That alone would mean a \$24 million savings over the past twelve years.
2. The Hospital Council's group purchasing program has saved an estimated \$35 million during this period of time.
3. Our hospital computer sharing system, in operation since 1969, has saved an estimated \$8 million to date.
4. Our management consulting services program has produced measurable savings of \$13 million.
5. Our prospective reimbursement method has generated savings to the community of \$37 million to date.

In sum, then, that means a savings to the people of Western Pennsylvania, from these programs alone, of \$117 million; not a bad return on a \$10 million investment.

I would like to conclude with some personal

observations dealing specifically with industry and labor, and to point out some fallacies that I feel exist in our national approach to the delivery of health care services and the costs involved in providing quality care.

I will repeat my conviction that industry and labor are interested in cost containment and are to a limited extent active participants in efforts to control health care costs. Certainly, there is evidence of this in Western Pennsylvania and I know of no reason why it would not be true in other parts of the nation. Industry and labor representatives have long served on the boards of trustees of our community hospitals, and they are active on the boards, councils and committees of the health systems agencies. From the beginning of our Plan forty years ago, industry and labor representatives have helped guide the progress of our corporation, generally supporting the cost containment activities in which we became involved.

Without their support our corporation could not possibly have achieved its standing as the seventh largest Blue Cross Plan in the nation. And it was industry and labor that supported our move to expand coverage into the outpatient area back in the mid-fifties, a move destined to relieve substantially the pressure for inpatient admissions. As a result, our program of outpatient benefits is now one of the most comprehensive in the nation, including coverage for: home health care services, care in skilled nursing facilities, care in physical rehabilitation centers and rehabilitation institutions for addictive diseases, preadmission testing, and same day surgery—all positive and productive steps toward the most economical use of health care facilities.

The other side of the coin is the questioning of the need for any use of health care services, and here the prime determinant must finally be medical necessity. The majority of our subscriber agreements contain medical necessity language and our utilization review activities rely upon this requisite in determining the priority of admissions, length of stay, services rendered, etc. Unfortunately, we have some major management/labor negotiated accounts where such language is not part of the agreement. This presents a real obstacle to a fully effective utilization review program within the community, and gives us no opportunity within these accounts to affect cost savings based on medically necessary evaluations.

It is not easy to convince negotiating parties to agree to minor language changes in existing long-term labor agreements, let alone to accept new provisions that in

any way may restrict the benefits already in place. Based on my personal experience, I consider this the most monumental understatement of my career. Nonetheless we feel that we are making some headway in convincing the parties involved of the importance of the medical necessity clause, and are confident that eventually we will succeed in getting acceptance of this qualification in all the programs provided by our Plan.

Despite the fact that I applaud the involvement of industry and labor in cost containment activities, I do not wish to imply that, in either case, overall performance fully matches overall capability. Both parties should, in my opinion, exert far greater pressure on health systems agencies to assure more effective planning of services and facilities than presently exist. Both should work together in developing in-house health education programs to reduce the incidence of illness and accidents, establish healthier life-style patterns, and assure early detection of disease. Both industry and labor could show much more active involvement in exercising their influence as hospital board trustees, and participating more fully in the management and operational problems of the hospitals. Of special importance today is their full support of the voluntary cost containment program which must succeed if we are to avoid further government encroachment into the health care system.

It would be helpful also if a way could be found to reconcile the many conceptual differences that exist in differing approaches to cost containment. Frequently I hear of industry representatives, political figures, and even providers of care themselves, who maintain that the real answer to cost containment is the use of financial gadgetry such as deductibles and coinsurance. This, in my opinion, is not cost containment. It is cost transference, and in the case of most of these people from industrial groups there is an abiding interest in rate containment. In no way is the total cost of care that is already provided reduced by deductibles or coinsurance. Simple arithmetic tells us that the addition of the patient's out-of-pocket payment to the amount paid by the carrier equals the total cost that was there in the first place. And there is no research that I have seen in thirty years that substantiates a reduced level of usage of health care services through the employment of deductibles and coinsurance unless the amounts are so high that they present a serious financial barrier to the person in need of care. And

where is that financial barrier most likely to occur? Obviously, it is in the low income segments of the population among the people who need the care most.

I would also suggest that the time has come for the verbal hit-and-run critic (whether from business, government, or any other area of society) to stop calling our health care delivery mechanism a "non-system"; to stop crying "crisis" every time health care is mentioned in any context; and to discontinue deploring today's costs of health care, while at the same time refusing to really pitch in and work with others in doing something constructive about it.

Our health care system is not perfect, but neither, to the best of my knowledge, is our transportation system, our educational system, or any manufacturing plant or process in the nation. I have no desire to downgrade the quality and integrity of business and industry. I know too well their contribution to the

preservation of the free enterprise system. But why call malpractice a cancerous growth in the health care system unless we are equally willing to say that product and equipment recalls for impurities or imperfections are also a malignant disease. Why characterize every aspect of the health care industry as a crisis problem? If there are indeed as many crises existing as news media are wont to report, it is little wonder that there is an increasing incidence of hypertension and other stress-caused problems.

I will end as I began, with an endorsement of constructive cooperation by all for the health care betterment of the people of this nation. Cost containment is our challenge and I am confident that working together we have the talent in this country to meet it. But it will take the best efforts of all of us, for cost containment is truly everyone's business, everyone's labor.

DISCUSSION

with Howard Gindele

CHAIRMAN FOSTER: I think we have time for just a few questions.

MR. MICHAEL BURACK: I would like to know if premiums for the kinds of coverage you offer are lower than premiums on similar kinds of coverage in other cities because of the cost containment measures you are using.

MR. GINDELE: You are speaking about a computer analysis of economic conditions in the various areas. If you take metropolitan industrial areas like ours, I would hazard a guess that we are lower, maybe not by much, but we are lower.

PROF. ALAIN ENTHOVEN: How many days per thousand per year are your people hospitalized or your beneficiaries in that area?

MR. GINDELE: This question has really puzzled us over the years. We have been doing cost containment work since 1958, as I mentioned in my talk, so this whole scope of cost containment is old hat. Not that we are not continuing to work hard on it, but despite all the things that we have been doing (and there are a lot that I have eliminated here for time) we have a high number of days per thousand subscribers.

We were challenged on that figure by the Insurance Commissioner at one of our public hearings, and we

have been puzzling over that for some time. So when the hearing was over, I consulted my research department. They are very talented people. I said, "Your first priority is to do a study on use of days per thousand across the country and find out why we end up with higher days per thousand."

Now it took about a year and three months to finish that study, and some of the things they found were rather interesting. They found out, for instance, that there are geographical differences, blocks of geographical areas that produce differences in the utilization of health care. They also found that the East Coast and the West Coast have the lowest days per thousand subscribers, and the closer you get to the Midwest and the middle of the country, the higher those days per thousand.

They gave me the report and I said, "Oh, what does that mean?" They said, "We don't know what that means. Now we have got to do another study." So we did a second study which lasted another year, and we found out some interesting things about our own area. We found out some of the things that might contribute to this. By the way, in Western Pennsylvania the general population days per thousand are higher than the rest of Pennsylvania. The Medicare days per thousand are higher than the rest of Pennsylvania, and the Blue Cross subscribers' days per thousand are higher than the rest of Pennsylvania.

From the second study we found that we had some interesting things to explore. First, we found out that probably the most important factor was the ratio of beds to physicians. If there was a high ratio of beds to physicians, the days were high. Secondly, in analyzing the physicians in our area, we found that the physicians who were educated in our area were staying in our area to practice. Then we went over to Philadelphia, and the physicians who were being educated in Philadelphia were staying in the Philadelphia area to practice, and they were using fewer days per thousand subscribers. So we came to the conclusion that there must be something in the manner in which our physicians are being educated with regard to the use of hospital facilities. We are trying to follow that, but each study leads you to a further study.

So to answer your question, ours are high. They are coming down. When we started out there were about 940 days per thousand subscribers. We are at about 850 or something like that. It is still high, though.

CHAIRMAN FOSTER: Do you see any connection

between that high utilization rate and the low per diem rates that you showed on the board earlier?

MR. GINDELE: No, I can tell you two other factors that I ignored. Our average length of stay in Western Pennsylvania is 6.3 days. That is lower than the rest of the state of Pennsylvania, but the rate of admission is high, and that is what we have got to key in on. Our rate of admission is considerably higher than on the East Coast. The average length of stay out on the West Coast, I sometimes see cited as 4.5 days, and women having babies stay three days. I don't know how they do it. They are healthier out there or they like to get back to all that jazzing around.

MR. PAUL A. HOFSTAD: The age of your population you said was second highest. Would that have a bearing on the length of stay?

MR. GINDELE: Yes, although we found from our study that age did not have the impact on utilization that we thought it had.

How Industry Can Help Hospitals Control Their Costs

JAMES MORTIMER

CHAIRMAN FOSTER: Our second speaker is Mr. James Mortimer of the Continental Illinois National Bank & Trust Company in Chicago. Continental Bank has been actively involved in recent years in the matter of cost control in the Chicago area, and we are very pleased to have Mr. Mortimer with us to tell us about those activities.

MR. JAMES MORTIMER: The preliminary agenda I got for this meeting indicated that a spot I am going to attempt to fill was laid out for an industry representative from Washington, D.C. I am not from Washington. I am from Chicago, and I might say that I am against Washington.

My job is Manager of Indirect Compensation here at the Continental Bank in Chicago. The Continental Bank is a member of the Washington Business Group on Health, and it is through that organization, I understand, that my name was obtained for this spot. So I ought to give them credit by explaining what they are.

Basically, the Washington Business Group on Health is a lobbying organization which is supported by businesses. The businesses that support that group are the major businesses in the country, the large banks, the large rubber companies, the large auto companies and so forth. This is a group that has been in existence, I guess, for about four years now and is trying to be responsible and vocal in presenting industry's perspective on this very complicated health issue.

I would like to thank you for the opportunity to come before this group. I stand here with some trepidation. I am not a health care expert. I am just an employee benefits guy who purchases some health insurance for bank employees. So I know I am not going to answer a lot of your questions. What I propose to do is ask three questions myself and try to answer them myself, and I hope that you will find that this is informative.

Let me first tell you the three questions I hope to pose and to elucidate. The first is: How concerned is

business over the health care cost issue? The second question is: Does business view these health care costs as being controllable, and what are some of the things that business is doing in an attempt to control them? The third question is listed as the title of this talk, and it is: How can business help hospitals to control their costs?

Looking at the previous presentation, I find that a hard act to follow, but one of the issues raised in that presentation was business labeling the health care cost increases as a crisis. I think that is not correct. I don't feel that business does actually feel health care costs increases are a crisis.

You have probably heard all too often the statement that was made by General Motors' Employee Benefits Manager, Victor Zink, and which has been misquoted, "People often say that there are more health care dollars in a car than steel." That is not what Vic said. Vic said that they have lots of people from whom General Motors buys things, and if they tally up their purchase orders, Blue Cross comes out on top. The next is Metropolitan Life Insurance, and the third is United States Steel. They obviously buy steel from more than just United States Steel, so when you are driving your new GM car, you are not driving health insurance. You are driving some steel.

Let's turn our attention to Continental Bank for a minute and get a little perspective on what my statistics look like. At Continental Bank our health insurance premiums have risen 82% in the five years between 1974 and this current year. Last year our costs for health insurance alone were \$4.4 million, and that is for a covered employee population of 8,000 people. That expense represents 3% of salary, 11.6% of the money we spent on employee benefits, and it does not include paid time off. The increase we have this year will make the corporate expense figure for health insurance alone rise to almost \$5 million.

These are large numbers, but they are small numbers when you begin to look at them, not from my perspective as employee benefits manager, but from the perspective of the corporate office where these things fit into the income statement. That figure in

1977 of \$4.4 million represents .3% of operating expenses. Those are small potatoes, and I would submit that most other manufacturing or service industries find that in their health expense, health insurance expense by itself is a small part of the income statement.

About three weeks ago I was in a meeting hosted by one of Chicago's hospitals, and I had the opportunity to attend that meeting because Continental Bank's vice chairman was unable to be there. Attending the meeting were several chief executive officers from Chicago companies or Chicago-headquartered companies, and the hospital called the meeting by the same name that I am entitling my talk: "How can business help hospitals contain their costs?"

Well, it quickly became evident that what the hospital was seeking was contributions. What they got from me was interest in cost containment, but I started out that meeting as I am starting out here, by contending that business really doesn't feel that the health care cost issue is a crisis, and that health insurance expenditures are a minor part of the income statement.

I was pleased to find that some of the other people sitting around the table, some of those chief executive officers, started to attack me. They said, "Wait a minute, bub. We are interested." So I see that as one example of an increasing concern at the executive officer level in business for these health care cost items.

I would characterize it this way. I would say that the health insurance cost is getting large enough and rising at a rate at which it is becoming an important item on the income statement, one that is attracting concern and attention from board rooms and chief executive offices. How controllable are these health insurance and health care cost expenses from the corporation's point of view?

I think if I were to answer that question in just a sentence, I would have to say that they are somewhat controllable but not nearly enough.

I would like to give you just a sampling of some of the actions we have taken at Continental Bank and that I have seen others take to deal with this problem from a corporate perspective. One action is negotiating like hell at rate renewal time on an experience rated health insurance contract. During the past two years, Continental Bank has avoided \$750,000 of health insurance cost by getting tough when it was time for rate renewal. We share the premium of our health insurance at the bank, and this has meant that

employees have saved another \$200,000 in payroll deductions.

I think that as health insurance costs started to climb rapidly about three years ago, health insurance fiscal intermediaries (can I use that word?), the carriers, got excited. They saw themselves in the middle. You could make a beautiful slide to illustrate that by taking the health care agency out of the middle of the vice and putting Blue Cross in its place, because they saw themselves between the health care costs and the subscriber's or customer's willingness to pay. What I saw them doing was buying themselves some room, and using trend factors that were a little generous and left room for error on the down side but not on the high side.

What we try to do at the bank, and what you as employers in the hospital setting might try to do also, if you are insuring your health insurance program, is to take those trend factors apart. Get them down to the little bitty pieces and find out: how much is in there for malpractice, how much is in there for doctors' fees, how much is in there for facility, and how much is in there for utilization. You will learn a lot I have found, and you can also have a chance to save some money.

The other thing you can do is begin to share the risk with the health insurance intermediary by using retroactive clauses under which, if you are wrong and the insurance company is right, you will pay them. If your guess about what the cost is going to be is right and he is wrong, you don't owe him any more, because you don't get any dividend back. You had the use of the money. You paid him correctly all the way along.

Another action is health maintenance organizations. We offered one back in 1974. About 500 of our employees signed up. Now there are more than a thousand employees in it. Today, a bulletin is going out to our employees announcing an open enrollment period for four more health maintenance organizations. This is going to have an interesting effect, we feel, because now an employee will have a six-way choice of where they get their health insurance: one insurance program, five HMOs. The benefits in HMO plans which are all separately managed are very comparable, and we think this is going to build competition among the HMOs because in many cases a person has geographical access to more than one plan's medical facility.

Our experience since 1974 with the one plan we

offered back then has shown that the increases in the dues in this case have been just about the same as the increase in the insurance program, but the difference is that we improved the benefits substantially, particularly in the unlimited risk area, when the benefits were moved into the qualified structure at the beginning of this year. If we had not made that benefit improvement, the increase in premium in the HMO plan would have been significantly less than the increase in the insurance program.

While offering this plan, there has been no real savings to date for the employer, but there has been a savings for employees. I am in the HMO, and I can tell you from personal experience that you wind up paying fewer total dollars for the same kind of health care than you would under an insurance program. The employer would expect to save money on this type of program in the future through the competition I mentioned, and through the economies achieved in hospital utilization. We expect to see those HMO rates fall below the health insurance plan rates, and at that point rather than peg our constant dollar amount subsidy of the health insurance program on the insurance plan, we will consider pegging it on an HMO.

When we went into the HMO program, I think we were convinced that prepaid health care was better and people were healthier under such a program because of early diagnosis, early treatment, and cost effective preventive medicine. I have come to believe that that is an ideal, but not really the true reason that health maintenance organizations are able to deliver care to our employees at 541 days per thousand last year as opposed to the comparable statistics in our insurance plan as mentioned before. I think the reason is just plain and simple responsible management of the use of the hospital resource. What I think we are seeing is that some of the unnecessary use of the hospital has been eliminated by doctors who are financially at risk for the cost of care. It is not to their advantage to use the hospital unnecessarily.

Another thing we and others are trying is to help employees become better or wiser consumers of health care services. For a long time we have helped ill people who come to our medical department without a doctor find primary care physicians. I think it is part of helping them get into a medical care delivery system at the right access point, as opposed to an emergency room, for example. We are trying some new things these days, and I would like to talk about some of these experiments.

Continental Bank is one of the companies that is

trying a second opinion program. We started it May 1 last year. We figure from looking at our hospital insurance statistics that we have got about fifty surgeries a month among our employees and their families, and during the first months of the program, May through December, we had twenty-four inquiries about a second opinion. Keep in mind there are fifty surgeries a month, so about 6% of the people who had surgery asked about a second opinion. Eleven of those people just asked and went no further. The remainder, we believe at this point, did go on to schedule second opinions which cost them nothing, and we know the results at this point of six such second opinions. There were two that involved a savings. One of the people with a knee condition, on the basis of the second doctor's advice, decided to try exercise, and feels satisfied with the results. There is a hospital stay and a doctor bill saved. Well, you can probably put a better figure on it than I. Another one decided to wait and see at least a year. So at least we got rid of that one for this year's claim experience. But the thing that is surprising is that hardly anyone questions the first opinion, and we find that the people that are coming to us already have some reason for doubt.

The doctor has made a very tentative recommendation: "Well, you ought to think about this," and so they are going to find out more. We are trying to encourage people to do this. We are working to enhance the activity level of the second surgical opinion program, and we don't feel that everyone who gets surgery, needs a second opinion. We are against a mandatory program of that type, but we feel that it is going to take considerable effort over a long period of time to internalize the way people think about deciding on whether to have surgery or not.

There is another program that we have come up with, and we started this one in June of last year. It is also experimental. We call it predetermination of medical insurance benefits. Our Blue Shield Program is a usual and customary benefit. It pays 80% of usual and customary charges. Through the years we have experienced angry employees from time to time concerning this benefit, and what happens is that when they have been in the hospital or had some work where the doctor has charged more than the usual and customary rate, he gets reimbursed directly by Blue Shield and then bills the patient for the difference.

For example, it is an \$800 bill, and the patient gets a bill from the doctor saying: "I have received your Blue Shield benefit. You owe me \$500." The person usually comes storming into our employee benefits office and

says, "There is something wrong. I have been billed too much by the doctor. The plan didn't pay enough. What do you mean offering this cheap health insurance plan?"

Well, in addition to attacking us, they usually attack Blue Shield. So what we try to do is to inform people who are curious ahead of time whether their bill will be beyond usual and customary or not, and this is called predetermination of medical insurance benefits. People who are curious get a form from us. They take it to the doctor or fill it out themselves with information about what is going to be done and what the price is. We work with our Blue Shield statisticians to determine, based on the information presented, what portion, if any, of that dollar fee will be beyond usual and customary and then play it back to the employee.

There is a low activity level here, too. During 1977, sixteen people asked about this program. We ran a good story, we feel, in our house organ early in January, and during that month, seventeen people asked about it. In February there were twelve; in March, four, so it looks as if it is time to hype that program again, but let me just give you a little flavor of it. We found last year, and so far this year, that of the people who asked: "Is my doctor's bill going to be beyond usual and customary care?" Half got a yes answer.

What do they do? Well, they think about it, and they usually go ahead and have the work done anyway, but they are a little wiser going in, and they don't come pounding on our door afterward. One person has decided not to have work as a result of finding out what the price would be. Those, I think, are two very interesting things that firms can do.

We are also talking to people about generic drugs. A law has been passed in Illinois that makes generic drugs more readily obtainable in a pharmacy and through a doctor. We also talk to them about outpatient surgery and some of the advantages that can have, particularly with young children who don't have to have a traumatic stay away from home for surgery that can be done in an outpatient setting.

As I mentioned before, we share the cost of our premiums. We share the cost of the coverage in the insurance program with our employees, and unlike the man just before me, we do feel that that does build some sensitivity to the cost issue, because we also keep telling people about it.

The next area of action I would like to point to is a long-range thing. It has to do with wellness. We have been screening people for quite some time at the bank

on the executive physical program, and I think that is the rudiment of wellness. A couple of years ago we instituted a multi-phasic screening program which does the job at a little less cost for a broader population. We are now looking at health risk analysis, health appraisal, where a person can answer a questionnaire stating his life style and habits. For example: "I always drink a fifth of booze and get in my car without wearing any seat belts and drive in excess of the speed limit." That does have some bearing on your life expectancy. These kinds of things can be played back to people.

We haven't installed it yet. We are trying to figure out how to use it, but we think this might be an effective way of getting people's attention on some of the basic life style issues in a wellness program, and we think it can also come before the application of any screening type of program or hands-on physical exam.

We have tried to teach people some things about wellness for a long time. We take a blood pressure screening and breast cancer self-detection as wellness. I think a lot of firms have done that, too, and there is some cost control interest here. We have just started to work with cardiopulmonary resuscitation, and we have advertised the local Tel-Med recording service to our people.

How about nutrition? Nutrition at work in a bank is pretty important because most of our employees eat in company food service facilities, and the thought has come to mind that maybe we are killing our people with kindness, poisoning them unwittingly, so we have undertaken a nutrition research program in connection with our food service. Our objective is to introduce one new healthy dish each month on the menu. Now we realize that that is only part of the job, and that a person also in many cases has a family sitting at home so we are probably not in total control of the nutrition program. This is something that we call research for the future.

Stress on the job. I am experiencing some stress right now. We feel that an employee counseling program helps people to deal with stress on the job. We have a unique program in our organization, I feel, because we have some licensed degree psychologists who work in it. We feel they are able to get to the root of the problem quicker than some people with lesser credentials.

We do climate studies in our management

organizations trying to help managers and subordinates identify problems that are pretty basic and deal with them so that they can remove those types of behavior problems from the environment. We cover bio-feedback in our program, and I don't think we have done enough with that, but having the reimbursement process will allow us to do some more things.

There are a lot of people spending a lot of money on fitness. I have been up to Sentry Insurance in Wisconsin. Some of you may have seen Employers' Mutual in Wausau, Wisconsin. You hear about Kimberly-Clark with \$3 million, \$4 million or \$5 million recreation facilities with indoor driving ranges and Olympic pools. Wow! I am not sure it is cost effective to set all that up in an industrial setting. What we are doing is trying to find a way we can introduce fitness into the life style, but to do it effectively.

I think what many of the people who have large fitness facilities find is that the individuals who use them are those who have kept fit anyway, and it's nigh onto impossible to get somebody like me who needs exercise, to go ahead and bite the bullet and get started. So that's still in the research stage.

Now for the payoff. How can business help control costs in the hospital? How can it help the hospital control its own costs? I have told you our own approach to it from our own perspective. Now let's look at it from yours.

I would like to start this part of the discussion in the context of the recent debate on the voluntary effort versus the Carter Cap. In the past few days this issue has gotten a lot hotter.

Rostenkowski, after his meeting with Carter, came out and met with the press, and I believe he said that of all the bills on the Hill that have come from the White House, HR-6575 has got the best chance of passing.

Well, there is going to be something happening, I guess, in Washington on the cost containment issue at the federal level, and I think with that threat in mind, we ought to take a very serious look at the voluntary effort.

Basically, what I am suggesting you do in your hospital's voluntary effort is to actively seek business support and ideas for solving the problems that you face. The hospital is a very complex institution. I am on the advisory board of one of the hospitals here in the city, and I took a tour of that hospital in the last few months. It's mind-boggling the kinds of things that go on in a hospital, so don't expect expertise on health care from industry. What an outsider such as a

businessman can bring to the party is a fresh perspective. You know, and I know, that we get so involved in our work that it is sometimes hard to take a fresh look at it because we just can't get far enough away from it.

Another thing industry can contribute is clout. Some of the problems you discover will involve more than just internal issues. They will involve external issues. If you have the right businessman working on your team, he will be happy in many cases to use some of that clout to help you solve those problems.

Business people, I suggest you will find, will be willing to volunteer human resources. Get a good businessman in your organization, and he can bring along some more help when it is needed; but let me say this: only the hospital can actually control its cost. The government can't control it. Business can't control it. Only the people who are making the decisions about what to do and what not to do, what to buy and what to save, can control costs. You make the decisions.

I am assuming that there aren't very many doctors in this room, but I would point out that from my perspective it takes heavy doctor support for the process to work well. I would suggest that most of what goes on in a hospital in the way of deciding care is done by a doctor, so you need to have hospital, doctor, and I would submit, the businessman as an adviser, working together to solve problems. I have seen doctors' support become much more readily available since the AMA Commission on the cost of medical care published its study. From where I have been sitting, that brought the doctors out of the weeds and into the picture on cost containment.

Hospitals have established a record for cost containment and for sensitivity to cost. We have all heard about the things they have done together in sharing services, sharing computer services, group purchasing, and group laundry. These things are a good base on which to build, but I think what needs to happen now is for all concerned to develop a state of awareness about hospital costs.

People getting health care are not price conscious. People buying services in business are. I think if you talk to a businessman about some of the problems, he may be able to find some good ways to solve them since he comes from a climate where cost is more important. By involving business in your inner thinking, you will probably get free advice, and many people think that free advice is worth exactly what you pay for it, but you will get a fresh perspective.

I would suggest that you need to internalize the issue

of cost as a second priority, a priority next to quality. This needs to happen from the top of a hospital right on down through the organization. It needs to become a state of mind.

I would like to go through an outline of how to focus on the cost issue at various points along the way. This is a little free advice.

1. You need to focus on the major expenses in your hospital, the major percentage changes and expenses. When we are trying to control costs at Continental Bank, the first thing we look at is controlling staff because the number of people working in a place is probably one of the most controllable things you have.

2. You need to cut out paperwork. Here is a place where I think automation and heavy technology in the hospital setting can pay dividends.

3. Many of the decisions I see made in the hospital are justified on the basis that they save time. I don't think this always generates saved dollars because many times what you have done is save elapsed time, and you are going to do more of those things in a unit of time, and it is going to wind up costing more, so I think when we are talking about savings of time, they are not always savings of dollars.

4. People expect hospitals to do what is necessary; here you need to question routine. "We have always done it this way" is the plague of sound thinking in business, and I am sure there are hospital procedures and hospital routines that could benefit by strong, open questioning. Do you always give the person that comes in for admission an x-ray? I have got a next-door neighbor who wasn't sure he had a heart problem. He called the emergency squad. They showed up with their shiny truck and eight firemen in their own trucks.

He said he felt pretty good as they took him out wired for sound and light and air, and you name it, and he is still in the hospital. I asked his wife the other day how he was feeling, and she said, "Well, yesterday they finally gave him the procedure. He was asking so many questions, and he found out that he was on day eleven of the procedure, and he had nine more days to go."

That's true. I mean, this guy is still in the hospital right here in Chicago. The routine procedure for dealing with a heart condition apparently is what they are following.

5. One other idea you might try is to involve the patient in discussions about what is necessary. At minimum, it is good public relations because they are going to feel more involved in the process, and I think in many cases the patient is largely responsible for recovery in the way he approaches the prospect of

HOW INDUSTRY CAN HELP HOSPITALS CONTROL THEIR COSTS

regaining health. It is also possible that a patient might be able to spot waste and spot things that he or she really feel they don't need.

6. Another suggestion I would make is to maximize the use of existing resources. This is another way to eliminate waste. At the bank, when we got computers, we spent a lot of money for them, and we figured for them to be worth it, we were going to have to run them around the clock. There is an awful lot of heavy capital investment in the health care business these days, and I wonder whether even though the place is open twenty-four hours a day, does it run at capacity or does it turn into a hotel at five o'clock. Here is an area where you can probably get better use of your surgical suite by adding an outpatient surgery program.

We have all heard about the hospitals in Las Vegas that offer bonuses for Saturday admissions. Pre-admission testing has been done before. Are you scheduling your facility on a five-day week or a seven-day week?

As you ask these and other questions, and hopefully get a good sounding board to work on them, you are going to identify obstacles:

1. There are going to be union rules that you will run up against and situations that the union won't buy.

2. Building codes can be a problem. I sit on an HSA, and they wanted to add a couple of beds to an intensive care nursery area. They had to redo the whole thing because if they touched one bed, everything had to be changed. Ridiculous!

3. What about Medicare-Medicaid reimbursement? The way your money comes in probably is constraining in some ways and presents obstacles.

4. What about Blue Cross procedures? Can these things get in your way?

5. We have heard an awful lot about defensive medicine, but I imagine that will be one of the obstacles to making needed changes that will improve the cost effectiveness of care.

6. What about excess capacity? How are you going to deal with it? How are you going to get rid of it, reallocate it, or reutilize it?

7. Does your planning agency put limitations on your program that are dysfunctional, that make it harder to control the cost effectiveness of care in your institution?

8. And lastly, malpractice premiums are large. I would imagine they have gone up somewhat in the

same way that health insurance premiums have. I am proud to say that Continental Bank is aggressively selling self-insurance trusts for malpractice. We find many eager customers for that type of product.

These are all issues that are external to your own hospital. I would submit that you should not stop at an obstacle, but face it. Raise the issue with your state voluntary effort committee. Press for a solution. Garner the support of the community, and here again I will include the businessman, in getting those issues to the right people and in the right perspective. Business

DISCUSSION

with James Mortimer

MR. ALEXANDER HARMON: I was interested in your last comment about involving business in our activities. How interested is business in getting into our activities? Particularly, I am concerned about chambers of commerce which are preoccupied with many, many other things that affect the economy of business and industry. We have found them to place concerns about health care costs somewhat to the side. I am wondering how you might be able to stimulate that interest from chambers of commerce.

MR. MORTIMER: I think chambers in various parts of the country have different perspectives on that. I have heard of some out in Ohio that are pretty involved, and I have been working with the chamber here in Chicago, the Chicago Association of Commerce and Industry. The main concern there is whether these costs are controllable or not. If the chamber and if business can start to see some ways to deal with the problem, they can act to help solve it.

I have seen some accomplishments here in Chicago in the last few months, but I would think that rather than go to the chamber to get some good business people to work with you on a specific problem in a specific hospital or group of hospitals, you ought to go to business directly, perhaps through your board of trustees or advisory board. Introduce the problem into the agenda at that level and pursue the acquisition of resource people to work with you.

MR. W. CHRISTOPHER CLARK: Do you feel that the day will come soon when industry will direct its employees who need hospitalization to those hospitals that have lower prices than other hospitals?

has long supported hospitals with monetary contributions, and I think that will continue, although it is going to be harder to round up those dollars.

What I would like to suggest to you if you are in the hospital end of this health care system is that rather than just look to business for dollars, look to it for some counsel, because I think you will find businessmen to be allies that have some expertise in solving the difficult kinds of economic and political problems that stand in the way of improving cost effectiveness. I would suggest to you that all you have to do is find a businessman and ask.

MR. MORTIMER: No, I don't see business doing that kind of thing. I can see an HMO doing that kind of thing.

A case in point is one of our HMOs here in Chicago that is hospital-based, but which has established facilities in the outlying areas that very eagerly took advantage of staff privileges at community hospitals where the cost was less than at the home base. HMOs are doing that, but I don't think an employer would feel comfortable getting involved with deciding or helping an employee to decide how to get his care.

MR. DONALD G. SHROPSHIRE: In working with businessmen on church committees, civic committees, a large variety of chamber meetings, airport authorities and other things, one often finds that the businessman does not come to his so-called charitable responsibilities with the same acumen that he uses in his own business situation. What can we do to have the businessman contribute the same skills and direction and motivation to these activities that he uses in his business?

MR. MORTIMER: I think the businessman here has to have an identity. I think he has to come to this hospital task as a consumer, as a representative of an employer that pays a lot of dollars for health insurance premiums, and I think with that hat on, he will have the type of clarity that will allow him to see some of these issues.

I think General Motors is the most outspoken in this area. Vic Zink says the people go to the hospital trustee meeting and leave their brains outside. What we are trying to do is get the people who go to those hospital

trustees' meetings to take their brains inside with them, and to give them some knowledge about the issues that will sensitize them and enable them to get on with the work. Maybe it is like an HSA where I am a consumer, and I find that many of the other consumers on the HSA really haven't got the basic knowledge it takes to challenge some of these questions, or to raise the questions. You need some level of knowledge before a person can do it. If you are going to take a businessman whom you know nothing about, I think you need to educate him, give him some basic training, before he can begin to be effective.

MR. DAVID McNARY: You mentioned that you are developing a program of health style or life style change for your employees. What is your primary motivation behind that? Does that help to reduce your health insurance premiums?

MR. MORTIMER: Controlling health care costs is one of the motivations, too. There are others. I think we are becoming convinced that people who are healthier, who have a fuller life, will also be more productive and will be able to rise higher in the organization.

More and more you, as employers, know that you have fewer and fewer options, less and less freedom in the people you select and the people you terminate. When a person comes to work for a company, and I think this trend will continue, you are going to be pretty well stuck with that person. He is your resource, and now it is your job to develop him.

People are critical of the school systems for not

turning out at the secondary level the kind of product that they used to, and I think firms are now responding with attempts to do some basic education for the new employees. As part of that fabric, I think business will be prepared to try to get people to live to their fullest potential and reap the rewards in a productive effort.

MR. MICHAEL BURACK: As background to this question, we did a study of costs in the state of Minnesota and basically said that there were four hospitals or five. The university, the two county hospitals and the VA hospital represent almost 50% of the hospital cost budgets in the state.

Now the question I'm asking is, from a business standpoint, do you see the role of trusteeship in governance of the public general hospital differently from the trusteeship in the community hospital because of the political and other larger implications there in terms of financing?

MR. MORTIMER: I really don't have a sophisticated answer for that question, but I would say there has probably been too much of a distinction drawn between public hospitals or government operated hospitals and community hospitals. I think they are all facing the same problems and they all ought to come under the same type of scrutiny and be viewed as a common resource at the community level, particularly in the context of health planning. I would hope that boards in those organizations would try to serve the same objectives.

PANEL DISCUSSION

Louis A. Orsini, S. Martin Hickman, Carl Stevens

Moderator: Richard W. Foster

CHAIRMAN FOSTER: We have asked two people to comment on the proceedings thus far, particularly on the most recent presentations, and both of our commentators this afternoon represent the much discussed third parties.

The format we will follow is to allow each of them to make a brief statement. Professor Stevens from the morning session has agreed to join the panel, and he will have an opportunity to respond to those comments. Mr. Gindele is in the audience, and he assures me that anything you would like to ask him, Mr. Hickman can answer, and he is already on the panel, but at any rate, we do have an appeals procedure. So if any of you ask a question and you don't like the answer, you can ask Mr. Gindele and I am sure he will support Mr. Hickman.

But our first discussant today is Mr. Louis Orsini, Vice President and Director of the Health Insurance Association of America. We are very pleased to have him with us.

MR. LOUIS A. ORSINI: In talking with Odin Anderson about this assignment, I said, "Really, what do you want from me?" I said, "If you want just a reaction, that is going to be easy. It is going to be very difficult, however, to keep my own personal bias from creeping into the act." He has given me license to give you a little bit of my personal bias, which has been accumulated over the last thirty years as a kind of student of the problem of cost containment.

The Association has some fairly definitive observations to make which most of you are familiar with, but I thought it would probably be useful to try to set some criteria by which we think the effectiveness of any cost containment strategy should be evaluated. Having set the criteria, I would then like to contrast the options that you have heard with the option that you are about to hear, and use that in defense of our strong preference for state prospective budget review legislation.

First, let me say that we think the cost containment

area represents a mix of things beyond our control that are inflating costs in a way that has to be accepted. However, it also represents the fact that there are practices which are unjustifiably inflating the base costs and which are not supportable. There is substantial evidence to document this, and therefore, any strategy has to be aimed at introducing an external pattern of accountability for evaluating key questions like the following: Is the hospital as efficiently run as it could be? Do we have the right pattern for distributing costs among patients, or are some bearing more than they should? Do some hospitals admit patients only when medically justified? Do they keep people there the right period of time in terms of medical criteria? Does the emphasis on defensive medicine influence the utilization of ancillary services? Do we have unnecessary surgery? Have we inflated the costs by duplicative and underutilized facilities and services? Do doctors overcharge? Do they increase their fees more rapidly than they should?

We think that in order to resolve the concern with whether or not we can reduce the rate of escalation in costs, we have to find some way of addressing all of those issues. Looking at the options that have been discussed, namely, the marketplace options—HMOs or health care alliances or others of the more prevalent types—the pragmatic application of these options is difficult in a system in which most people like prepayment, not postpayment. The trend is in the direction of paying more, not paying less, because costs are rising to the point of causing strong resistance to expanding cost sharing.

Government continues to do its own thing. Unless we, in the health insurance industry, develop a strategy which involves government, the notion that the money that isn't paid by government is going to be paid by somebody else will continue to be perpetuated. You have got to recognize, too, that as we look at the overall question, we have got to have a common and accepted objective of management. The administrator, the governing board of a medical staff, must agree that addressing these issues is in the hospital's long-range interest.

The health insurance industry does not think any of the fragmented control concepts that have been discussed lean upon the enlightened self-interest of the provider. We must introduce enough practical external leverage to achieve that result.

In looking at marketplace controls, we say: "How are you really going to change the market, when 88% of the people like it the way it is? How are you going to organize purchasers to make informed judgments when, in fact, the principal option that they want to retain is the right to choose and change a doctor?" They would really be ill-advised to challenge his judgment of how to manage their case once they have selected him, except in the rare situation in which the patient does ask to be put in the hospital for a diagnostic workup.

Looking at the options available to carriers about things we ought to be doing, we are doing most of them. We are broadening our coverage to cover the cost of outpatient and diagnostic workups. We are providing coverage to pick up care for home health services, an alternative to acute care hospital admissions. We are introducing coordination of benefit provisions to discourage over-insurance. We are introducing the option for alternative delivery systems where they are available and where they are economically viable. We are introducing restraints on the evaluation of physicians' charges to determine whether or not they are consistent with community criteria. We are utilizing peer review. But when we get through doing all of those things (and some of them do generate some short-range savings), we find that we fail to address the basic cost issue. All we have done is shift cost from one place to another.

So the emphasis, we believe, has to be placed on the hospital budget, and that is where you must start your evaluation. We think that there are certain key characteristics of an effective budget review system, none of which are in use today, that are effective in accomplishing what we must achieve.

Some administrators have succeeded in slowing down the rise in costs, but they look good because the rest of the system is out of control. There is room for improvement, and I would like to discuss with you some of the things that we think have to be included in a state prospective budget review system.

The Health Insurance Association of America is encouraging, incidentally, the enactment of federal legislation for a long-range strategy to establish guidelines under which rate commissions ought to operate for the care rendered to all patients. That is a

very important caveat and the first of the critical guidelines.

The second important consideration I think, is that when you move to a global budget review system, you have got to figure out some way to integrate the decisions which control capital expenditure and to evaluate fluctuations in total revenue due to intensity of volume changes. Unless you have that latter capacity, you will find that the wide range of fluctuations in intensity that occur make the whole process uncertain. If you are really going to look at the opportunities for moderating the rise in costs, you have to provide the administrator with a strong incentive to re-evaluate departmental costs and decide whether he can become more efficient. We think some of the rate regulators have carried out that role pretty well. There is a plateau effect occurring in that area. While there is room for more improvement, the overall money saved is not that large and you reach the total saving level quickly.

Another area that is very critical to this whole problem is the definition of full financial requirements. If we are going to have a uniform definition serving as a uniform rate, which we think is fundamental, it is necessary to integrate government into the reimbursement patterns. Medicare and Medicaid continue the present strategy of reducing payments retroactively. That shifts costs to the patient or shifts it to the charge-paying patient, and we don't see any promise of their relaxing that pressure, so we have got to figure out some way to force them into the same reimbursement system. We think that the way to go has been shown in what has happened in Maryland.

The last point I want to emphasize is the one we think affords the largest opportunity for improving the system, and that is the question of what the doctor does. All current efforts to elicit a response to the question have failed. The doctor generates 70 to 75% of the revenue made by the hospital. PSROs have become highly controversial regarding their cost effectiveness, and we understand why they are controversial. For the most part, they have been limited to Medicare and Medicaid because they put the medical staff in the conflicting position of being expected to reduce occupancy levels and save money for government at a time when hospital costs are rising more rapidly than ever. Still, we think that the review process is necessary to achieve cost containment, and that what we need to develop is an external audit system to determine

whether a process is being carried out objectively and with sufficient credibility, and whether it is being applied to all patients. We are working in one area to develop this kind of audit system as a contribution to solving that particular problem.

Everybody talks about the impact of rate regulation on quality, and I think it is a great opportunity for us to introduce the issue of quality into the debate. It becomes part of the dialog as you look at budgets because without a method of evaluating quality and utilization, budget review becomes a meaningless exercise.

Finally, I would point out that the health insurance industry agrees with the notion that there should be some long-range price differential, but one that reflects the advantage to the hospital, because the whole bill is paid at discharge. The criteria on which the differential is based should be promulgated by the state agency administering the program and made available to all patients who qualify.

Now in retrospect, why did we lean so heavily in this direction? We did it because we have observed that in the states of Connecticut, Maryland and Massachusetts, with their imperfect rate regulation systems, but with common principles, there has been a significant slowing down of the rate of escalation in all patient revenues. Note, I didn't use average cost per diem as an indicator. That is too vulnerable to manipulation when utilization changes. I didn't use daily service charges because that leaves out the impact of increases in outpatient services and increases in intensity, but I am using the all-patient revenue test because we think that is the bottom line measurement of what is taken out of the community in total, and therefore, properly reflects progress or lack of it in restraining the rate of escalation in cost to the community.

We have observed that most of those rate regulation programs have achieved their results not with the effective evaluation of quality assurance, not even by effective coordination with planning, but largely because of the fact that some of them have defined full financial requirements differently. Some hospitals have been applying controls earlier. Some have not applied them because they feared that if they had to justify their budget, they couldn't ask for as much money as if they didn't have to justify it.

We also noticed that rate regulation does provide unique leverage as a common objective to bring together the governing board, the administration and the medical staff in the creation of a strategy for

affecting quality, management efficiency, price in equity, and the expenditure of capital. Further, we think that certificate-of-need standing alone is going to have very little effect on the rate of escalation in costs, but combined with a budget review system, it does generate the kind of leverage that produces a positive incentive to merge, convert or mothball underutilized services and facilities.

So I guess we come out with saying that we agree with all of the options, but we are skeptical about whether they are going to generate the impact that is needed to stimulate a re-examination of the real problem areas. Our preference does not mean that we won't cooperate with the voluntary cost containment effort.

We think there is room enough to try many options. We have legislation in only five states, and in only four of those are programs really being fully implemented today. We are pushing for more legislation, but that isn't going to happen overnight, so there will be ample opportunity to demonstrate the credibility of the options.

We think when we get all through that the value of a state-operated system as a uniform basis for reimbursing hospitals—which makes government another purchaser sitting at the table exerting just as much influence as everybody else, but no more—gives you the best opportunity to recognize what you are doing is supportable and offers the best form for challenging the things that are not supportable that you need to change. Thank you.

CHAIRMAN FOSTER: Thank you, Mr. Orsini. Our second discussant is Mr. S. Martin Hickman, president of the Health Care Service Corporation. I think most of you know what that is. In most parts of the country, you see Blue Cross-Blue Shield in the name somewhere. We are very pleased to have Mr. Hickman with us.

MR. S. MARTIN HICKMAN: Just a little bit of a clarification. I am president of Chicago Blue Cross-Blue Shield and not the national one or the Pittsburgh one or any of the other sixty-nine in the country.

I am a little bit uncomfortable. Jim Mortimer mentioned the feeling of stress. I am supposed to comment on some statements made by a medical economist. I am not an economist. I am supposed to comment on statements made by a colleague, and that is kind of tough, and I am supposed to comment on

one of our major customers who just skimmed us out of \$750,000 he told me, and that puts me on the spot, but we will manage.

I am going to take a little different tack and just try to pass along some reactions I have to various thoughts that were presented by the speakers this morning. There is no particular theme running through this, but I guess I would say these are the feelings of somebody who often feels like Mr. In-Between-the-Customer-and-the-Provider-of-Care, and then there is a third person, the regulator, nowadays.

First, I would like to package my thoughts here about Professor Seidman and Professor Stevens; just a few random thoughts. The first is in regard to the marketplace strategy as an approach to addressing hospital cost containment or health care cost containment.

If I understand what is being said here, the idea is to get the patient, in particular at the point of service, involved more in the decision making on health care issues, by means of coinsurance, deductibles, limits, benefit designs and to get the physician by means of, I guess, patient pressure, to become more interested in costs.

I am not sure how practical that is, at least at this stage, and I guess maybe this is what Lou Orsini was commenting on. How do you really get the patients at that time to be interested in the economics of health care?

We have heard Jim Mortimer mention that Continental Bank has had a second opinion surgery program, and I think he said six or eight people have taken advantage of it, because it was a tentative situation. Continental's employees also have had a special program to enable them to estimate what Blue Shield was going to pay ahead of time, so that they could make a decision as to whether they wanted to use a particular physician. Few have taken advantage of that program. I am just not sure that this is ready to fly, at least at this point.

I will have to say that I agree and disagree with Howard Gindele to some extent on co-payments and coinsurance and related features. I believe they do have an impact on health care costs, but I doubt that that impact is very significant. At least, I have not seen many studies that suggest it is, until the payments get so substantial that they, in effect, pose a financial barrier to the people who need care the most.

The credit card idea that was suggested this morning in Dr. Seidman's presentation, I think, has great potential. I think it is probably limited to the group

insurance field and not to the people who would buy health insurance individually. I think there are some who would have to be tightly underwritten or government financed, and I will tell you that what the government finances, it regulates. Still, I think that has a great deal of potential, and as a matter of fact, I know that some Blue Cross and Blue Shield plans are experimenting with it. In fact, I think the Western Pennsylvania plan did that several years back with a deductible program.

Physician involvement is a tough issue. It is asking the physician to make judgments and recommendations at the point of service while he is treating a patient and is expected to give his patient the highest quality of care; that is usually what the patient is interested in at that time. He may change his mind three or four months later, but at the outset he wants the best service and the highest quality care. It puts him in a great dilemma. Take suggesting that he be involved in the billing process. At least in the Chicago area and in the state of Illinois a great deal of the billing process goes through a billing service, and the physician knows very little about what happens. If the hospital were to bill through the physician, I am not sure just what problems that would cause.

However, the payoff, I am convinced, is in influencing the physician, and I believe it is in a long-term education process, not so much in the sense of somebody teaching you something, but in constantly making available information, so that he can see what the nature of the results are, or what the nature of the impact of his individual decisions is, in an aggregate form. I think the health insurance industry and the Blue Cross and Blue Shield industry are in a unique position to provide this sort of data and educational effort, and we are doing so.

Tax credits: I have never really thought much about those. I am not quite sure. I am sure that tax considerations are a significant item in union negotiations as to what benefit levels are available, but I am not sure on an individual selection basis how much of an element in the decision-making process that is. The same goes for giving the person a cash equivalent.

The fact is, as Lou Orsini mentioned, the American public likes first-dollar coverage. They are used to it. They like broad, comprehensive coverage. There are a number of alternate plans like the federal employee programs which offer a variety of benefits and where

the employer, the federal government, pays a very small portion of the total fee. In that instance, while there is not a cash equivalent paid, there is a cash equivalent that doesn't have to be paid if you pick a low option benefit; but consistently over the years high benefit comprehensive programs have been selected over low benefit ones.

We have had the same experience here in Illinois where we have had optional programs, and that is pretty much the case in any experiment or major effort I have seen in this. So I think the idea that people will make those decisions, and that with a cash option you will significantly change the pattern of health care is overly optimistic.

I guess I would sum up by saying that physician and patient involvement in marketplace environment strategy certainly is something to be considered, and probably is beneficial, but don't expect too much—at least not very soon.

Professor Stevens did mention an item which I think is extremely central and that is the role of the triumvirate of a hospital board, the medical staff and the hospital administrator. I am not an authority on the evolution of the hospital system in the United States, but the perception I have is that historically the hospital was the workshop of a physician. The administrator was hired to run the workshop, and the board was there to raise funds.

That has certainly changed in some circumstances, but it seems to me that it has to change in such a way that these factions coalesce into a single, unified group working towards a common objective. I think the catalyst that is going to make that happen universally is at the hospital board level. That is the area where, it would seem to me, that change will get the most momentum. Until the board becomes involved, hospital administrators are in a difficult position to deal with the situations that must be faced in this issue, and they cannot act effectively in an adversary role.

Physician involvement at the board level, whether it is on the board or in some other official role, seems to be essential because without the efforts of all people with a common commitment to the solution, it doesn't appear that any relief will ever occur.

Moving on to Howard Gindele's and Jim Mortimer's remarks of this afternoon, I guess I would like to comment on those both at the same time, too.

Blue Cross and Blue Shield have been working very hard, and I would have to say that Western Pennsylvania, among the Blue Cross plans, has the reputation of being the cutting edge of most of the

efforts. The Blues have been working very hard in a whole variety of cost containment programs and with the business community. All of the programs that Howard mentioned and that Jim mentioned have some potential for controlling hospital costs. If you think of that leverage, I think Western Pennsylvania's program netted an eleven-to-one return. That is pretty impressive, but the important thing is that it does take leverage, and I am convinced that it takes a cooperative effort among business, the health insurance industry, the Blues, the health care system, and the regulators.

An adversary relationship has not accomplished much in any instance that I am aware of. The objectives are the same; as soon as people take sides, I think the dialog ends and very little is accomplished. It doesn't mean there always has to be agreement. Adversity and adversary roles certainly help sharpen the issues and the willingness to agree to disagree often is as valuable as to agree to water down agreement.

I would add to that, that the role of the business community in providing clout can be tremendous, and I think the Blue Cross-Blue Shield System, and the Health Insurance Association, should help mobilize that clout. We have access to thousands of employers at the top. There is no reason why we can't play a very major leadership role and help the health care system, including the hospitals, address the issues.

I have skipped Dr. Kimmey's comments this morning. I guess I was in such total agreement with them that it is hard to comment meaningfully. I am much like his father-in-law. My father was even more that way, so that he looked out the window *every* morning and spoke of Mr. Roosevelt. It is hard for me, or not natural for me, to say that government involvement or government-sponsored programs are going to have a major payoff because in most sectors, I really think that the marketplace strategy is the correct one. But I really don't think it is likely to happen soon enough to affect costs.

The importance that Dr. Kimmey placed on the HSAs, I think, cannot be underestimated. This, to me, is one of the most promising creative designs of grassroots input. I realize that they are politicized very often, and underfinanced very often, but they have all the potential that we could desire to help bring local attention and input into decision making in the health care field. I think the alternative decisions being made at the regional Social Security Office are so gross that we should be very supportive to HSAs, although we may be very frustrated in these beginning stages.

I think you probably all have heard of Murphy's Law and Parkinson's Law. There is another law called the Satanic axiom. It goes something to the effect that no matter what the problem is and no matter how complicated it is, if you look hard enough, you can find a single devil who is responsible for the whole thing. Then there is a corollary to that, that goes: the more complicated the problem, the more time you will save if you will apply the axiom.

Now I think that perhaps we get ourselves into that syndrome when we address the health care issues. The real solution, it seems to me, is more like a series of ads I think Union Carbide has been running: "there are no simple solutions, only intelligent choices."

The real fact is that a whole series of pressures and motivations must be brought to bear on the problem of health care costs, and necessary changes will not be made, and frankly, I don't think should be made by means of government intervention. The solution will require a concerted and cooperative effort by the third party payers, the health care professionals and providers, and the regulators, and it seems to me that regulation is inevitable. The only question is: Who is going to be the regulator and who is going to be the regulatee? I would propose that we can do it better ourselves with our own initiatives than government can.

CHAIRMAN FOSTER: In keeping with the times, we don't have any shortages here today. Particularly, we don't seem to have any shortage of diversity of views on how to approach the problem of retrenchment.

I think we will start the open discussion by giving Professor Stevens a chance to respond to the discussants, and the other speakers thus far.

PROF. STEVENS: Let me try to be brief. I think there are some crucial issues before the house, and I think it is quite important that we undertake directly to address those issues.

I think that perhaps they come together in the discussion of whether the market structure strategy of cost sharing is in the cards. One thing I think we are in grave danger of is misapprehending the significance of cost sharing, the significance of that kind of market solution. The significance of having cost sharing is not just cost containment per se. In fact, cost containment per se is a most peculiar kind of planning objective; to say the least. Contain cost to what level? Currently, the

health care sector is using on the order of 8 to 9% of the gross national product. Is that too much or too little? Would 5% of GNP be too much or too little? Suppose this affluent society were spending 15% of its gross national product on health care. Is that too much? Who says it's too much or too little, and how do they rationalize it?

What we are seeking is not an ill-defined non-goal like cost containment. What we are seeking is a system which will yield the right, or efficient, or in some way socially sanctioned, rate of resource allocation to the health care sector.

This, of course, is what cost sharing is all about. If cost sharing were acceptable, if consumers confronted prices in the marketplace for the great range of their health care expenditures, their market behavior presumably would testify, just as their market behavior in general testifies, that the tradeoffs are worth it. We have got to keep our eye on that significance of what cost sharing is all about. It is not just a case of shifting costs from third parties to out-of-pocket payments by consumers, and it actually doesn't make any difference from the point of view of the logic of this system whether in point of fact we turn out to spend more or less for health care. The point is that with this kind of system our behavior in the aggregate testifies that the rate of resource allocation is the right, socially sanctioned, rate of resource allocation. That point, it seems to me, is very crucial.

Now a second problem with the market strategy of cost sharing that has been alluded to is its practicability. Is it a lively option? One opinion is that it is not a lively option for the simple reason that regulation and central planning are fait accompli. They are here to stay.

I must say I find this a terribly discouraging kind of siren song that we are getting at this symposium. I don't think, however, we ought to be conned into believing that regulation and central planning are in fact fait accompli. The reason I don't think central planning, which is what HSAs are, and regulation are here to stay, is because I don't think that they are responsive to our basic problems.

I have no reason to suppose that HSAs, or planners in any other guise, can produce a plan which represents an authoritative statement about the rate of resource allocation and mix of resource allocation that I and all the rest of the consumers in my service area prefer. I have no reason to suppose that planners' preferences

sensitively and properly represent the preferences of consumers in the aggregate with respect to the rate of resource allocation to this sector.

I think it is by no means the case that planning and regulation are necessarily here forever. The option of greatly reduced regulation should be regarded as still open. Now if, indeed, we were to go this route, then it would be necessary that cost sharing be a lively option in the sense that folks find it acceptable. I addressed that issue this morning. I think the important issue about cost sharing is whether or not people really want it. If they don't, then the way in which we approach efficiency in the health care sector must be changed radically.

We might conceivably get employers to offer their employees a choice between conventional first-dollar type coverage on the one hand or cost sharing type programs on the other. Give a check for the cash difference in the premiums that the employer would have to pay.

What about tax treatment? The Ways and Means Committee is now meeting on aspects of President Carter's tax reform proposals. It has rejected the suggestion from the administration that health care premiums not be deductible for tax purposes. If at the present time that committee would go the other way and simply say, "Look, we will add to what is deductible for tax purposes any cash payment made to an employee representing the difference between the typical health care plan and a less expensive one that he elects," so that from the point of tax treatment those things are on a par, and this option were offered generally throughout industry, we would see whether employees would choose it.

I think that it isn't enough to say that 88% of the folks like prepayment. The way the system is set up with employer contributions to health care plans and the tax system the way it is, the amazing thing is that only 88% of the folks said they like prepayment.

If you can get it set up in such a way that it is a fair choice, I am not persuaded that 88% of the folks would think that it makes sense to prepay all of their health care. In any case, it is an open issue. It is an open question. What is crucially necessary at this juncture is that realistic tests be made because it seems to me that everything turns on that. If cost sharing is not a lively option, then the way in which we approach the efficient organization of this sector must be radically different.

CHAIRMAN FOSTER: Would either of the panelists like to respond to that?

MR. ORSINI: I can't resist the temptation. I don't think that we should lose sight of the fact that I tried to establish some objectives for a cost containment strategy. If you don't agree with them, I would like to find out why.

It seems to me that you only reduce the rate of escalation in costs if you change something that is now happening, and the things that ought to be changed that are now happening are the practices that are unjustified—that are wasteful of present resources.

We have got to get a handle on the problem of inappropriate admissions. We have got to get a handle on the problem of ordering too many tests. We have got to get a handle on the problem that the doctor takes out too much healthy tissue. We have got to get a handle on the problem of the fact that there are hospitals with severely underutilized facilities and services that are permitted to continue to operate because of a lack of incentives for their personnel to seek out better options; these are concerns that you must address if you want to do something about rising costs. I guess I find it difficult to figure out how that marketplace strategy can exert the necessary pressure on the governing board and the administration and the medical staff to make them respond to those issues. I am willing to be educated, however.

PROF. STEVENS: If I could take just a minute because I think this is quite crucial. I was at some pains to say that I thought cost containment was a non-objective. I would be very interested if you would tell me to what extent you think costs ought to be contained.

The way in which cost sharing presumably is responsive to these kinds of problems, particularly if it is combined with a better way to harness the physician to the purchasing agent role, is, as I suggested this morning: presumably the physician takes into account along with his patient not only the efficacy of alternative treatment regimens, but also the cost of those regimens.

What the consequence of that in terms of utilization of services will be, none of us can predict, and moreover, what is crucial, none of us knows what it *ought* to be. I don't know. None of us at this table know what is or isn't "necessary" surgery. The way a decision gets made properly about that is when a fully informed patient and his physician, looking down the barrel of the costs of alternative treatment regimens and, taking into account the risks, reach a genuine two-party conclusion. What is "unnecessary" surgery for Peter may be "necessary" surgery for Paul.

So I think that we are talking about getting inefficiency out of the system, if we have informed consumers, consumers informed about the opportunity costs of the care they wish to consume.

Now there are other kinds of inefficiencies in the system which, of course, raise different kinds of problems. There is excess capacity in the automobile industry. General Motors is running full tilt; Chrysler is losing money hand over fist. American Motors has empty plants and empty assembly lines. Some years ago Packard went out of business and so on.

I don't hear a hue and cry about costly duplication of facilities in the automobile industry. The reason I don't hear that hue and cry, of course, is because since automobiles have prices hung on them, we assume that the market is expressing some sort of informed judgment about whether the rate of resource allocation to this output is worth it in terms of foregone alternatives. And we accept the fact that if there is any dynamic element in the system at all, e.g. tastes change, the location of populations change, the appeal of organizations change, there is going to be excess capacity all over the place which gradually will be squeezed out. This is the perennial gale of creative destruction.

As to the health care industry, we fret about costly duplication in a way that would be regarded as preposterous in any other industry. We fret about cost containment in a way that would be regarded as preposterous with respect to any other industry. The reason we do these things is because, given the way the industry is financed, we can't believe that it can be running efficiently. Given zero costs at the choice point for most of the \$140 billion worth of goods and services in this industry, nobody can believe that \$140 billion represents a reliable social judgment about what ought to be going into this industry.

We should recognize that one of the important reasons we have this big cost containment emphasis at the present time is because the federal budget is in trouble, with little discretionary leeway. As Medicare and Medicaid costs mount, the federal budget is becoming increasingly tight, and in some sense the federal budget authorities do have a genuine cost containment problem; but surely we in the health sector don't want to address policy in this sector by saying that our objective is some unspecified thing called "cost containment."

CHAIRMAN FOSTER: I see that Mr. Orsini has his hand on the mike, and let's make this the last comment

before we open it up to the floor. I don't think that is an onerous restriction. You will have a chance to say whatever you want in response to questions regardless of what they are anyway.

MR. ORSINI: You heard me before. What you are getting is a rationalization of his strategy, and I would simply like to highlight two points of difference. The first point of difference is that the consumer knows enough about how he ought to be taken care of to influence physician judgment and do it in a way so that the end result is going to be the right result.

My objection to that is that the guys to whom the doctor pays attention are his peers. So the consumer must identify a problem and get him to change, and I haven't seen anybody else who has been able to get him to change but his peers. I want to highlight that difference in approach.

The second problem about government's concern with cost is that while government is concerned, they yet have an option which they are taking advantage of and that is called Public Law 92-603. The reason that those of us in the private sector are concerned with that option is that if our costs are going up 17% annually, they are going up 25% because \$3 billion a year is being added to the private sector because of government cutbacks, and we just don't think we can afford to ignore that trend for the hundred million people that we insure. We have all got to figure out some way to stop it and then correct it, and unless that is part of your strategy, we think what we are going to end up with is to perpetuate that. The gap is going to widen, and customer dissatisfaction with what we have got is going to increase to the point at which they are going to seek more desperate solutions.

The last observation. We can't ignore the fact that what is now being discussed as a federal strategy is a cap which affects all revenues. You cannot ignore the fact that what is now being discussed is a long-range cost containment strategy that affects the care rendered to all patients, and if we are going to stop the drift in the direction of an arbitrarily administered federal standard, we have got to create a realistic option which we can offer that is going to be more responsive to the problem.

CHAIRMAN FOSTER: Okay, anyone in the audience can direct questions at any or all of the panelists.

DR. EVERETT A. JOHNSON: I would like to ask Lou

Orsini a question. As usual, he is articulate and pungent in his observations, but he suggests that there should be research done on issues that we are supposed to handle. Now he lives in a state, it's called New York, in which cost containment has had a very heavy effect, and it has particularly affected the price of insurance policies.

Why hasn't the private insurance company decided to pull out of New York completely, and confront the government and private industry?

MR. ORSINI: If I had my way, they would have. Unfortunately, we deal with national organizations. National organizations have multiple locations. For all practical purposes, if you are a New York domiciled concern, you don't even quote on the case because the arbitrary administration of a law which has produced over the last three years a rate of increase in the cost for Medicare and Medicaid of zero, three and 6% while leaving charges totally unregulated, has resulted in differentials of 45 to 50%, and nobody in their right mind is going to opt for that kind of a choice. We are working very hard to bring this to the attention of people, but when you represent 11% of the marketplace, and that is held up before you all the time, and you are going to adversely affect the other 89%, or at least they allege so, it is hard to get a constituency to pay attention. There is no question about the fact that the confrontation is already coming, and we are gradually having our position eroded to where the results you are talking about will occur within the next four or five years. There is just not a practical option for us.

MR. LEWIS FREIBERG, JR.: I have got a couple of observations that I would like to throw out to the conference. One of them is that it seems that what I am hearing is that there is not really any cost sharing going on right now. It is something that we ought to try. It is virgin territory. It is my impression that a large part of the commercial insurance business indeed combines coinsurance and deductibles. Blue Cross and Blue Shield plans in the individual states are going more and more to explore coinsurance and deductible policies primarily because premiums are going so high on full coverage. It seems as if, where I live, that is an option. It is not, then, a question of whether we should try it or not. We are trying it on a relatively large scale.

The second thing I would like to get some comment on is this whole notion of cost containment. It is really a misnomer. When economists speak of costs, they generally speak in terms of value of resources used to

produce a given level of goods and services. Government regulatory cost containment, really expenditure containment, concerns price and utilization of price and quantity. Now the cost is included in the price so that if you talk about restraining expenditures, you are talking about holding down services as well.

I wonder if the public would be as interested in cost containment if it were suggested to them that well, somewhere down the road it might mean waiting in line for two or three weeks or several months to obtain surgery that somebody thinks is elective.

MR. HICKMAN: Let me speak to the first point on cost sharing and its practice at present. Undoubtedly, it is widely practiced now. I guess the point that I would hang my hat on is that the trend has been away from that. In the beginning, in the commercial insurance business (and this is not so in the Blues) it was almost completely a cost sharing proposition with indemnity limits and such, and has since moved to the major medical approach. Lou Orsini would probably have the figures; I don't. The pattern that I have seen emerging, and that we see in the marketplace, is one of first-dollar coverage on hospital care, particularly with wrap-around major medical sorts of coverages very often, but it is after the first-dollars.

Now there is a comprehensive major medical which sometimes has first-dollar on the hospital side; but not always and not generally is my impression.

I forget your second point. I did have a comment on it.

MR. FREIBERG: My second point was the misnomer of cost containment really meaning expenditure containment which implies something about the level of services that will be available.

MR. HICKMAN: I guess my personal reaction to that is that people don't believe that. It may be very true that that is what would happen, but they haven't experienced it, and they don't foresee it or believe in the possibility that they will have to wait in line. They think that it won't happen to them, at least, in any instance.

Rightly or wrongly, so much attention has been brought to bear on the presumed redundancies and inefficiencies in the health care system that consumers believe that that is where attention should be directed and solutions found. That is my personal evaluation.

PROF. STEVENS: Yes, I think on the first point it is crucial because we have been using cost sharing as a

kind of code word for what commonly is called maximum risk type plans or something of this sort. What is in mind is not just some coinsurance and some deductibles which amount to more or less minor out-of-pocket expenses for consumers, but plans that really mean the consumers must face large potential out-of-pocket outlays.

I think Professor Seidman, this morning, did discuss the kind of plan that I assumed we were calling cost sharing an income-related sort of thing. The example he used was for an individual earning \$20,000. The maximum risk he had built in there was \$2,000. In other words, that individual could be looking at a total out-of-pocket outlay of \$2,000 for his health care. So it is cost sharing such that the great bulk of medical expenditures are paid for out-of-pocket, not just nuisance type deductibles and nuisance type coinsurance. I think that is quite important.

Now we always say income-related, equitable and so on. The way the society has put this together is as follows. The society subscribes hopefully to the dictum: "Nobody shall be denied health care owing to inability to pay." Operationally, that can be defined in terms of some socially acceptable terms on which health care shall be available. Presumably people with very low incomes pay nothing. People with very high incomes would have a higher percentage per year of total maximum risk than others. The idea would be to have substantial cost sharing, which is not true now. Now 90% or more of all hospital bills are paid by third parties. That is not substantial cost sharing for the single most expensive health service.

DR. RONALD ANDERSEN: I have a question for Professor Stevens. It's appealing to think that we have a market mechanism that will reflect the preferences of the population in aggregate. However, you did bring out, I think, a very important point, that most people subscribe to the belief that everyone in the population should have access to some level of medical care regardless of their ability to pay for those services. Now how do we take that into account? I think your suggestion and Professor Seidman's suggestion, this morning, had to do with some kinds of judgments made about how much people should pay according to income level either in terms of tax credits or coinsurance and deductibles related to income levels.

One question I have is: it seems to me that when we begin to make those judgments, then we aren't really using a direct market mechanism, but are imposing values which immediately fail to reflect aggregate preferences. We are just superimposing value

judgments about how much people should pay according to their means.

The other question is: we talk about including some cost sharing mechanism in a national program or in a voluntary program, and obviously a very important determinant is bargaining for fringe benefits, and what percentage of the cost to the employee, or the individual, the employers might pick up.

Now I understand that one argument that might reduce this is changing the tax structure, but I wonder, in fact, how much we could change it, so that it would be politically acceptable. I could see possibly taking off the benefits that accrue, but could we actually think that a program which in addition penalized the employer who is offering such a benefit would be politically realistic?

PROF. STEVENS: I don't know whether I fully understood both of those questions. I will try to make some comment. I think on the first one the answer is a short one, that you are right. I think it is an interesting question. You can't have your cake and eat it, too. In other words, I think we do have a certain amount of "specific egalitarianism" loose in the social order regarding ways to do something about what we regard as inequitable distributions of income.

With respect to some things like food and housing and health care, we say to ourselves: "Things ought to be distributed more equally than they would be distributed if left to the marketplace alone," and we distribute in kind. We give out, in effect, in kind. We give out food stamps. We give out rent subsidies, and we give out health insurance premium subsidies.

I think if we are going to serve that social objective, then obviously we are taking at least that much out of the marketplace, and I don't think there is any way around that. I take it we say to ourselves, "It's worth it. It's worth it to compromise market allocation to this extent for this reason."

I think on the issue of where the cutoff is, what maximum risk for an out-of-pocket payment the society judges complies with the dictum that nobody shall be denied needed health care services because of inability to pay, I think that that is a social judgment that we generate much the way we generate the judgment about who gets how many food stamps and who gets what rent subsidy.

I think that one might think of ways to improve the sensitivity of that social decision-making process. But I don't think it is very different from kinds of social

decision-making processes that you make in other domains. No doubt the market is to a considerable extent compromised to the extent that you do. I think that is right.

On collective bargaining on fringe benefits, among the constituencies with a major interest in national health insurance have been the labor organizations. This is because they see that health insurance premiums are eating up an enormous percentage of their benefits. There is only so much blood in the turnip, and what you wring out by way of health insurance you can't wring out for something else. So the health insurance premiums are running anywhere from \$500 or \$600 to \$900 or \$1,000 per employee per year. If that burden could somehow be unloaded on the taxpayer—taken off the employer and put on the general public—then, in principle, there might be more available for other fringe benefits.

MR. P. TIMOTHY GARTON: I have been wanting to ask Mr. Hickman a question on an issue brought up by Dr. Kimmey this morning.

You seem to have two conflicting schools of thought on how to go about containing the total bill for medical care. One is that the individual's decision-making should be attacked by the reduction of co-payment deductibles, that the individual making payments should somehow see the effect of the decision to assume certain amounts of care and in terms of out-of-pocket expenditures. The opposite is that somehow the institutions or the professionals are at fault. Mr. Orsini seemed to say that the true cause of over-expenditure is professionals making inappropriate kinds of utilization decisions. Rather than dwell on questions of what institutions can do to harness professionals and cause them to make the right kinds of decisions, and rather than deal with the economics of some of the situations, I would like to ask Mr. Hickman if he believes in your-fault insurance. And to Mr. Orsini, what fault might the insurance industry have in fostering an inappropriate demand for health care on the part of individuals who might subscribe to their different kinds of programs. And what kind of moral suasion can be placed against you to educate individuals about appropriate utilization of medical care resources as opposed to placing the onus of educating the public solely on health care professionals?

MR. HICKMAN: There is an old saying that your point of view depends on where you sit, so I guess I don't really see that there is a fault at this point

anyplace. The things that have happened in the health care field and in the third-party payment field are natural things that have happened to meet specific, felt needs at particular points in time, and I think the idea that there is a major amount of fault we should lay on somebody—

MR. GARTON: No, no. Maybe you misunderstood what I meant by your-fault insurance. You smoke. You got lung cancer. It's your fault.

MR. HICKMAN: I would have to admit that that is not an item I really am knowledgeable about. Is it an insurance program or is it an educational project? Lou?

MR. ORSINI: We support the notion of health education. We have got to face the fact that no matter what we do in the area of health education, it is going to be a long-range strategy and the jury is very much out on whether people want to change their behavior. Somehow it is always the guy who says, "You drink too much, but not me. You smoke too much, but not me."

This does not mean that we don't have a stake in trying to develop effective programs of health education. We are trying to do that at the national center. I think the short-range problem that we have, however, is that the patient wants to pick a doctor. He wants his doctor's judgment to control taking care of him. Somehow he doesn't have any confidence in the insurance company's judgment taking care of him, and I don't blame him.

Now we have got to accept that assumption and protect that assumption because that is the one thing that the average individual is making as a choice in the marketplace and probably the only decision he is making. You can't escape the fact that once you have made that choice, the burden of determining whether or not the doctor is using good judgment is on his peers. The hospital medical staff must judge his competence.

We can't say that there is no need to check on him at all because there is too much evidence that utilization patterns follow availability of services. There is too much evidence to confirm the fact that unnecessary elective surgery happens to vary with the number of surgical specialists. There are too many symptomatic evidences of the fact that we have problems that require in-depth examination, and all we are saying is: Let's get the medical staff to do it, and let's do it in a credible and objective way so we don't have to retreat to some other way, to interfere with physician judgment.

CHAIRMAN FOSTER: Something that may be related to what was being asked, although it may not be specifically related to life style, is what Mr. Orsini alluded to briefly in his comments about activities being undertaken to discourage over-insurance. I wonder if you could clarify what over-insurance you are talking about, what the actions are.

MR. ORSINI: What we are talking about is the fact that when an individual sets out to insure certain expenses, most of our major medical plans intend to carry some degree of co-pay, coinsurance, or deductible.

When he has two plans because his wife works is the most frequent cause of having two plans—he has more coverage than the actual insured expense. At that point we think if we give him the full amount of coverage, he has got a strong profit incentive to influence physician behavior, so we are saying: let's give him 100% through coordination of benefit provisions of the insured expense through the combination of plans, but let's not give him a profit. Most group plans apply coordination of benefits. Most individual policies are prohibited from doing so by present insurance laws, and that is where the problem still exists.

CHAIRMAN FOSTER: So you are saying that if you pay more in benefits than the guy spent, it is over-insurance and otherwise it is not.

MR. ORSINI: Of his insured area of expense, yes.

CHAIRMAN FOSTER: I guess economists typically would talk about opportunity costs of time and they would say in a case like that, that if you take into account the time that the guy had to put into receiving service, that he might not be overcompensated at all.

MR. ORSINI: That is true, but on the other hand, we didn't set out to insure that. We set out to insure his expense for medical care treatment, permitting him to recover 100% of that, and once we start getting into the area of insuring through a medical care frame for disability benefit, we have distorted the function of insurance. There are other forms of coverage to do that.

MEMBER: I would like to move back briefly to the marketplace. I would appreciate a comment from any member of the panel or all three on where we should continue to increase the numbers of health professionals, health providers and institutions or professionals, in order to have a stronger competition

in the marketplace by reason of the increased numbers or, on the other extreme, to limit the number of professionals, institutional providers, etc., in order to limit access to the system.

PROF. STEVENS: I don't know. That is a tough question. I think I am the only economist in the country who believes that we can get enough physicians so the competition will set in among them. I think the most common view is that somehow this is a peculiar domain in which supply creates its own demand, and the more physicians you have, the larger the proportion of the GNP that will ultimately go for health care.

My own answer to this problem which may or may not make any sense, is that I don't know what number of physicians is the "right" number of physicians. I am no more capable of planning on that front than I am capable of planning the "right" number of hospital beds; neither does Secretary Califano know what the right number of hospital beds is, his pronouncements to the contrary notwithstanding. But I think we do have a problem in the medical school sector, in the sense that this market obviously isn't cleared insofar as the students are concerned.

For every first year place in the medical schools, there are four or five students wanting to get in, so you might say just by that criterion that we don't have enough places in medical schools. The problem, of course, is that we have an enormous public subsidy of medical education, and given this public subsidy, it is an awfully good deal.

I think what we probably ought to do, is what Clark Kerr suggested many years ago. One of his early Carnegie Commission publications was a report on the medical schools, and he made the suggestion to shift much more of the burden of the cost of medical education on to the student and combine it with an appropriate student loan program.

As far as I am concerned, we ought to have this for all higher education. We ought to have a loan program with the following characteristics. Any student who can get in and maintain his position in school, including medical school, can borrow the full cost of that education. Repayment would be on an income related basis such that we would have a repayment schedule that wouldn't indenture anybody. If, for example, when you get out of medical school, you want to be a barefoot doctor and work for practically

nothing, you don't pay anything on the loan that you have had. On the other hand, if you are the representative orthopedic surgeon and you are making \$80 or \$90 or \$100 thousand, your payoff schedule is rather substantial.

We can predict fairly confidently, with respect to the 15,000 or so students getting out each year, what in the aggregate they are going to end up earning, and we can set up an actuarially sound income related payment scale.

The beauty of this is that nobody is indentured. The big problem with student loan programs is the inadvertent indenturing of students in consequence of debt acquired. Nobody is indentured, but students are picking up the tab for, let's say, substantially the whole cost of their medical education.

If we had this kind of a scheme, and maybe some grants to recognize that there may be some cultural situations in which people, for one reason or another, are fearful of debt even under this kind of repayment arrangement, we could forget the physician shortage problem or the physician surplus problem.

When you get most of the public subsidy out, keep in only as much public subsidy as is justified by the public good nature of health care, we could forget this manpower problem, and I don't really see any other reasonable answer to this.

If a kid wants to invest in a medical education, to pay the cost for this kind of education, he may be our guest. That would be the criterion that we would apply and we would let the medical school market clear itself.

The Medical Staff and Cost Controls

STEVEN A. SCHROEDER

Professor Ronald Andersen, Graduate School of Business, Associate Director-Research, Center for Health Administration Studies, University of Chicago, presided over the third session.

CHAIRMAN RONALD ANDERSEN: It seems to me that one thing that might be stressed in this symposium on creative retrenchment is the need for clear and effective communication to prevent misunderstandings between physicians and administrators, for example.

It reminds me of the case of the young physician who was asked to speak before the local medical society. It was to be an informative and also an entertaining occasion, so he discussed with his wife what he might talk about.

He had recently purchased a sail boat. He was very involved in it and decided that he could do something on sailing and health. So he spent a great deal of time working out his talk with his wife's help.

The day arrived. He kissed his wife and went off to give his speech. On the way he began to think this was really an inappropriate topic. What could he possibly do?

He had an old standby talk on sex education, so he went along to his meeting, changed his topic and gave his talk. He went home that evening and got up early before his wife was awake and went out to make rounds.

Later on the wife was downtown and ran across a colleague, a young physician. The colleague said, "Mary, I want to let you know what a big success your husband was last night," and the wife said, "Well, you know, I am really surprised to hear that. He doesn't know much about the topic. He has only tried it twice. The first time he was seasick and the second time he lost his cap."

Well, our topic today, I think, is quite apropos given the discussions that we have had yesterday. The physician does seem to be a key, and certainly the interaction between the physician and the administration is very important.

Our first speaker today is Dr. Steven Schroeder, Associate Professor of Medicine, the School of Medicine, University of California, San Francisco. He

is also a member of the Policy Center there directed by Phil Lee.

I am pleased to learn that Dr. Schroeder not only has insight, but evidence. The title of his talk is "The Medical Staff and Cost Controls."

DR. STEVEN A. SCHROEDER: I would like to talk today about the physician and cost containment and about the impact that will have on the jobs that all of you are trying to do as you relate to the issue of cost containment in the hospital sector.

It has almost become a cliché that, as Victor Fuchs has said, the physician is "the captain of the team" who controls the expenditure of medical dollars. Economists estimate that about 80% of all health care expenditures result from decisions made by physicians. Admission to the hospital, the length of hospital stay, the use of hospital resources, and the work of pharmaceuticals, laboratory, and x-ray services all result from decisions that physicians make.

I think that 80% figure is a little bit high because it underestimates the impact of consumer demand, but the decisions of physicians certainly have to be the largest single determinant of our medical expenditures in this country, and therefore the focus of this session is appropriate and timely.

It is timely because of the well-known concern about the rising costs of medical care, and it is appropriate because attempts at cost containment will have to anticipate and understand the behavior of physicians.

I would like to review briefly three aspects of physician practice variations: first, the extent to which doctors vary in the use of medical services; second, the relation of such practice variations to variables such as physician competence and outcomes of patient care; and third, the important determinants which influence a physician's decision to order particular services, because I think in order to design cost containment strategies one has to be knowledgeable about why it is that physicians behave as they do.

There are certain things I am not going to talk about, but they are also very important, and most of the things about cost containment I will be saying in

this short period of time I can't cover extensively. I will not talk about regional variations in the use of services, which is a very fascinating field dealing with the difference, for example, in hospital length of stay between the East and the West Coast, the cost implications of which are very great. I won't get into much detail about the effect of HMOs and that kind of group practice organization on the utilization of care. I would like to start—Dr. Andersen will be pleased with this—by saying a few words on methods.

The literature on differences in physicians' use of medical services is small, and it's skewed with reports from medical teaching centers and from prepaid group practices. Many of the studies also suffer from an inability to control for today's mix. That is, the severity of disease in one center is not comparable with the center that it is being compared with, making it, therefore, very difficult to know to what extent differences in physician use patterns are due to differences in the severity of the patients they are taking care of.

Then there are a set of methodology problems such as, what do you call an SMA12, for example. Is that twelve tests or one test? Those problems are highly technical.

One fundamental problem that gets at all discussions of expenses generated by the medical care system is the difficulty in separating cost from charges. For this discussion I am going to focus on costs to the consumers or the payers; not the real, itemized cost from the hospital prospective, but the charges that are paid by the consumer.

Most of the data on variations of physicians' use of medical services relate to laboratory tests and procedures. Freeborn and his colleagues at the Kaiser-Portland Health Plan showed increasing laboratory use from 1967 to 1970 with internists, my specialty, leading the field.

They also showed marked variations in individual patterns of laboratory use. The same physicians tended to be high or low over time; amount of usage did not appear to be due to differences in case mix, although Freeborn et al. didn't specifically present data to that effect.

A more recent study from Kaiser-Portland found tremendous variation in the use, for example, of throat cultures for patients with upper respiratory infections. Individual internists cultured from 0% to 75% of all adult patients coming in with sore throats. They also cultured throats twice as often as pediatricians did.

Carl Lyle and his colleagues described the practice

habits of a group of eight internists who practiced in Charlotte, North Carolina. They looked at almost 4000 contacts between physicians and patients during a three-month period, and they showed a very significant variation at the less than .001 level in volume of laboratory studies ordered by these physicians. The variations held true for all aspects of laboratory work including clinical chemistry, x-rays and EKGs, and were not correlated with the subspecialty areas of the internists.

When I was at the George Washington University Medical Center we did three studies of physician variation in use of lab tests.

One report compared charges for laboratory and x-ray use by thirty-three faculty internists who cared for a homogeneous patient population in the general medical clinic. Figure 1 shows that among these thirty-three physicians, there were tremendous variations, actually eighteen-fold from the most expensive to the least expensive, in the cost generated by the use of laboratory services. When we looked a little more closely at these variations, we couldn't attribute them to clinical characteristics of the physicians' patients or to physicians' characteristics, themselves.

The left side of Figure 1 shows lab costs generated by these thirty-three physicians. The right half shows the impact of an audit that we did, and I will get back to that later, but the point I want to show is the tremendous variation. When we tried to correlate that with characteristics of the patients or the physicians, we found that we couldn't tease out any criteria such as degree of training, or where the person went to medical school. None of those factors seemed to account for the differences in practice variations.

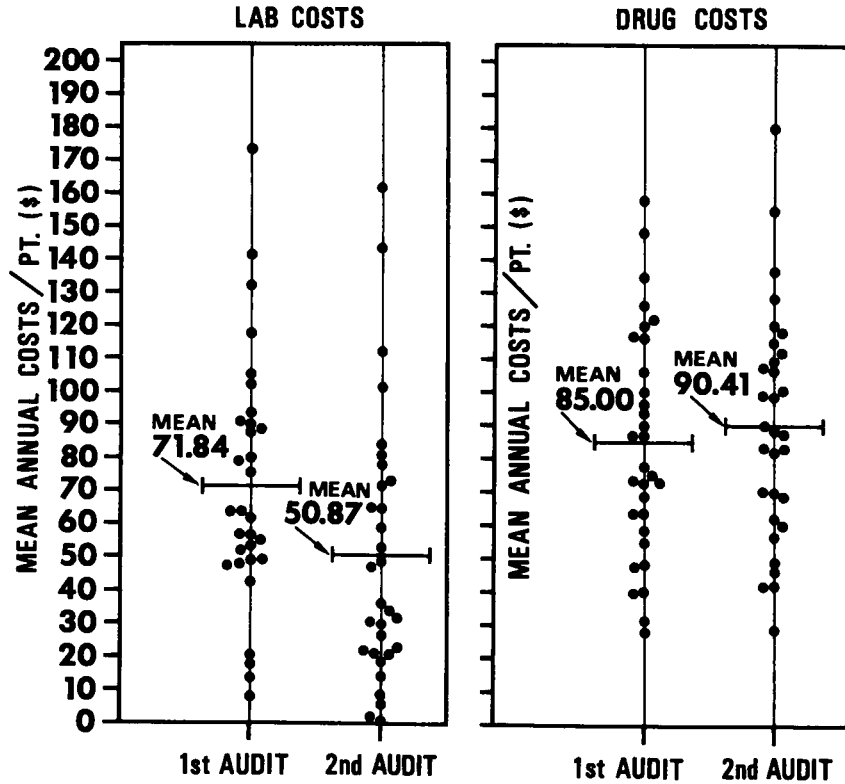
Our second report compared costs of lab use generated by twenty-one medical interns for patients hospitalized in the coronary care unit. We chose that site to try to control for case mix.

When we attempted to construct the profile of the lab costs that they had generated, we showed less variation, but it was still great.

The third study looked at cost of laboratory use for ambulatory patients generated by thirteen faculty internists; we controlled for case mix by using only patients who had a diagnosis of hypertension. Again, variation in the use of lab tests was extreme. This time it was about twenty-fold, and with a standard deviation of almost one quarter of the entire variation.

Other studies from family practice models, from a general medicine clinic and a hematology clinic have

Figure 1
Distribution of Mean Annual Lab and Drug Costs
Among Physicians During The Two Audit Periods



all reported significant differences among providers in the use of laboratory services.

So to summarize this aspect, all reports showed great variation in the use of laboratory tests by comparable physicians even when you control for case mix, and the variations are not obviously related to specific physician characteristics. Although most of these reports come from ambulatory settings, there is a suggestion that the variation is less extreme in the hospital setting, perhaps testifying to the more collegial nature of medical practice in the hospital setting where rounding and supervision and audit are a more formalized part of clinical care.

Let's leave laboratory services for a moment and look at variations in other medical services. Probably if you exclude laboratory or x-rays studies, variation is best documented for surgical services. Noteworthy are the studies made primarily at Mt. Sinai by Ed Hughes, who is now at Northwestern. Hughes and his

colleagues convert all surgical operations into hernia equivalents as a means of expressing surgical workloads.

Hughes first studied nineteen general surgeons in a private practice community in suburban New York. The annual number of operations per surgeon varied from 47 to 569, with a mean of 200 and median of 165. The annual number of hernia equivalents varied from 43 to 625 with means and medians of 208 and 147, respectively.

The national SOSSUS, Study of Surgical Services for the United States, confirmed on a national basis the local variations that Hughes reported.

It seems reasonable to assume that similar variations take place in other medical services, although documentation to that effect is minimal. For example, the report from Charlotte by Lyle showed statistically different rates of return appointments, use of outside consultants and hospitalization for the eight North Carolina internists.

Two important questions come out of these differences in the use of physician-controlled medical services. First, what are the benefits to patients and to society in general from varying rates of use of medical resources? Or, as the economists put it, and you probably heard last night: What are the marginal benefits that derive from the next test, the next procedure or the next hospital day? The second question is: What influences physicians to use more, or less, medical resources?

I would like to focus the next part of the discussion on these two questions, which I think have great import to all of us. First, let's examine the relationship between cost and quality. I can think of at least four hypotheses between physicians' generated medical costs and the quality of care.

The first is that there is a positive correlation. Physicians who order more laboratory tests are more thorough, more conscientious, and the higher cost of laboratory use is reflected in higher quality of medical care.

The second hypothesis is an inverse effect, that there is a negative correlation. In that case, high users are those who are less clinically competent and must buttress their judgment by documenting quantitatively aspects of the patient's care, whereas those who are more competent don't need to resort to this kind of support.

The third hypothesis is that there is no relationship: that, for example, lab use is related to individual personality characteristics such as how compulsive or insecure one is, or it may reflect variable concern with cost of medical care, depending on the setting and the physician's own motivation, but really has no quantitative relationship to quality.

The fourth hypothesis was described to you last night. It is that at the early part of the curve, one does get a return, and then one reaches the flat of the curve, and from that point on there is very little, if any return. I think the debate in the medical community is: Where are we on this? Some people think we are here and others think we are out there.

Unfortunately, exploration of these four hypotheses is just beginning and is complicated by the primitive methodology we have at present to measure the quality of medical care. There are really only a handful of studies that relate cost to quality.

Freeborn and his colleagues use Internal Medicine Board certification as a surrogate for quality, and I think that is not a terribly strong surrogate. He found that the Board-certified physicians had lower rates of

lab use than other physicians, so again this would support the inverse relationship.

We described lab use profiles for twenty-one medical interns with patients in the coronary care units that I mentioned earlier. We correlated rank order of the interns according to cost profiles, with rank order of the interns according to their estimated competence by faculty supervisors, and we found an R of -.13 which is essentially zero correlation. So we supported the random correlation hypothesis, a theory that at least in that setting, there didn't seem to be any direct relationship.

In a further study we compared charges from laboratory tests for ambulatory patients with hypertension for the thirteen faculty internists, and we correlated lab use profiles with clinical outcomes using control of blood pressure as the dependent outcome variable. A large, but not statistically significant, negative correlation of -.42 resulted. When we looked more carefully, it didn't seem to be that the physicians who had patients with poor outcomes had more difficult patients, and we tried to control for that factor.

I think all of these studies should be thought of as preliminary and should highlight the need to look more closely at the implications of differences in style of medical practices.

It is likely that a very large number of cost benefit curves exist for individual physicians in individual clinical situations. The shape of these curves would vary according to patient variables, a particular clinical situation, and the set of determinants which influence the behavior of physicians.

It does seem clear that increasing national concern about the cost of medical care will result in increasing pressures for physicians to make explicit the marginal benefits resulting from increased use of costly medical resources.

Let us now turn to why physicians use medical resources. Table 1 shows eight important reasons and incentives for physicians to provide a particular service. The list omits variables such as the extent of medical insurance coverage in order to focus more directly on determinants of physician behavior.

Perhaps the most common and important reason for a physician to perform a medical service is the belief that it will enhance the quality of care provided. Unfortunately, as I just mentioned, there is very little data to document the incremental contribution to quality of specific medical services.

A second factor is patient demand. While there are

Table 1

Factors Influencing Physicians to Order Medical Services

1. Belief that more service will improve quality of care
2. Patient demand
3. Fear of malpractice suits ("defensive medicine")
4. Fiscal incentives
5. Medical practice variables (group vs. solo; prepayment vs. fee-for-service; medical specialty)
6. Educational background of the physician
7. Knowledge of costs of medical services
8. Participation in medical teaching

no good indices by which to measure changes in patient demand over time, if we measure it inferentially from space devoted to medical news in the popular press, then we would guess, and I think with some certainty, that patient demand and patient interest, particularly in the benefits of new technologies, is increasing.

The third factor is fear of malpractice suits. The practice of defensive medicine is ordering services, especially procedures or tests, more with an eye on future litigation than on the patient's actual health status. Again there are few reports or empirical studies

THE MEDICAL STAFF AND COST CONTROLS

to document the impetus to perform medical procedures that result from fear of possible malpractice suits, but it does seem that many physicians may have shifted postures from "if it can help and can't hurt, do it," to "if in doubt, do it, as it may avoid my having to go before a judge."

A fourth incentive is fiscal returns. My colleague, John Showstack, and I have discussed in a paper published in the April issue of the journal, *Medical Care*, the incentives for providing services created by the existing differential valuation of medical care services. In that paper we presented four theoretical models of general internal medicine office practice.

The four model practices consisted of fixed ratios of history and physical examinations to return visits, with numbers and types of medical procedures and laboratory tests increasing stepwise through the four models. The difference in the models of practice was the intensity in which the practice used laboratory procedures.

All models assume that the specialty of the physician was internal medicine, that the distribution of the visits between patients getting a history and physical exam and those getting a return visit was constant, and we only looked at patient care occurring in the physician's office.

We assume that office care accounted for about 85% of the internist's patient care time with the remainder being hospital care.

Table 2

Percentage of Patients Undergoing In-Office Procedures and Tests According to Practice Model

Procedure or Test	Model A		Model B		Model C		Model D	
	H & P*	General **	H & P	General	H & P	General	H & P	General
EKG	0	0	40	7	75	10	75	10
Urinalysis	0	0	100	20	100	30	100	30
CBC	0	0	100	15	100	20	100	20
Sigmoidoscopy	0	0	25	3	50	5	50	5
TB skin test	0	0	90	3	90	5	90	5
2-view chest x-ray	0	0	0	0	0	0	75	10
Stress test	0	0	0	0	0	0	20	1
SMA-12	0	0	0	0	0	0	75	10

*H & P = History and Physical (22% of all office visits)

**General = General return visit (78% of all office visits)

Models A, B and C in Table 2 assume that the physician was in solo practice. Because of the larger capital investment required for equipment, Model D assumed a four physician, general internal medicine group practice. No procedures were performed in the physician's office in Model A. Five basic procedures and tests were performed in Models B and C. These were an electrocardiogram, urinalysis, complete blood count, sigmoidoscopy and tuberculin skin test.

As shown in the table, the basic differences between Models B and C were the percent of patients receiving each type of ancillary service, generally with more patients in Model C receiving ancillary services than in Model B. Three additional diagnostic procedures were performed in Model D. These were two-view chest x-rays, a cardiovascular treadmill stress test and an automated twelve-channel blood chemistry test.

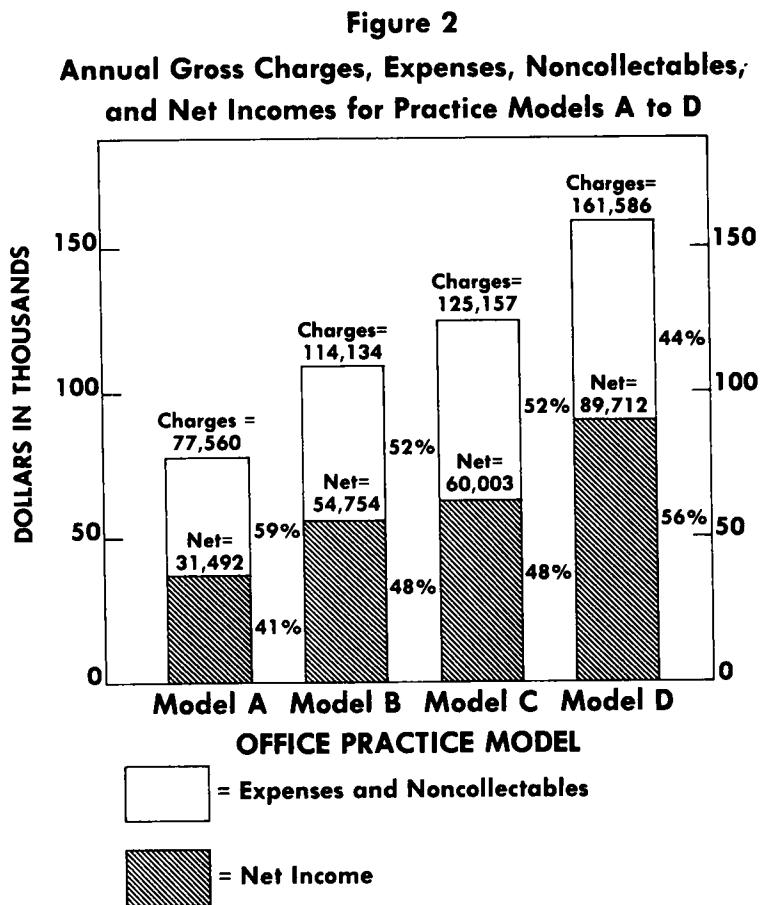
Each model assumed that the equipment for these services was either loaned or leased by each physician or group.

Since this study was an attempt to illustrate incentives to order ancillary tests that are built into the reimbursement system, revenue and fee assumptions

were based on the system as it now operates. As a proxy for a random sample of fees, a charge for each office visit and ancillary service was derived by using a relative value for that service as described in the 1974 California Relative Value Studies, a scale quite representative of existing valuation for medical services. We then multiply that value by the dollar conversion factor that is used by the California Division of Industrial Accidents when that state uses California Worker's Compensation Laws.

To account for additional physician time spent in performing and reviewing the results of procedures and tests, which would reduce total patient volume, a decrease in patient volume was built in, for Models B, C and D (5, 10, and 15 percent respectively). It was assumed that nursing assistants and lab technicians would actually carry out most of these tests with the exception of performance of sigmoidoscopies and supervision of stress testing.

Now for the punch line. Note the income statements for each model as shown in Figure 2. Net income for Model A, in which no procedures or tests were done in-office, was about \$31,000. When the procedures and



tests were performed at progressively higher levels of intensity (even with a moderate decrease in the number of patient visits) the net income rose. Model *D*, in fact, had a per physician net income almost three times that of Model *A*. Net income increased from 41% of the gross charges in Model *A* to 48% in Models *B* and *C*, to 56% in Model *D*.

The income discrepancies shown by these model practices demonstrate the financial incentives that arise for expensive medical care from our present fee-for-service pricing system. These incentives probably have a great deal to do with the higher physician incomes generated by surgical specialists, pathologists and radiologists.

The fifth factor influencing physician behavior is the structure and organization of the practice setting. Abundant evidence exists that physicians in the prepaid group practice model of health maintenance organizations produce less hospital use. It also appears that in HMOs use of medical technologies such as fiberoptic gastroscopes, computerized tomography scans, and coronary bypass surgery may lag behind the fee-for-service system.

Empirical data also show that physicians in fee-for-services group practices have a greater use of (and resultant profit from) ancillary services such as laboratory and x-ray tests than do solo practitioners.

A difficulty in comparing medical use across different specialties is that specialists tend to care for different types of patients with different clinical problems. Although some documentation of interspecialty differences does exist, the data do not provide a consistent picture of this effect.

Let us move on now to physician education. It has been suggested that the type of clinical exposure at both the undergraduate and graduate levels is important in shaping subsequent clinical behavior. However, again, the data to document this hypothesis are scanty and somewhat conflicting.

One study from the Kaiser-Permanente Program in Portland concluded that physicians trained in medical schools and hospitals that have "a scientific medical orientation" use fewer clinical and technical resources than other physicians, except under conditions of diagnostic uncertainty. In other words, the more highly scientifically trained doctors may have been using the resources in a more appropriate manner. On the other hand, two studies from our group could not explain variations in cost behavior by these criteria.

Knowledge about absolute and relative costs of medical care is one other factor that might influence

cost behavior. For example, in the study shown in Figure 1, the difference between the first audit and the second audit (a 29% decrease, significant at the $<.01$ level) was probably due to circulation of a cost audit that ranked the physicians. The audit was coded so that they didn't know who the others were but could see their cost performance on a relative scale so that they could compare themselves with their peers.

This was a setting where the physicians were salaried, and didn't have any direct financial stake in the cost of their care. There was an impressive degree of interest generated by this audit and I think an impressive change in behavior.

It was interesting also that cost reduction was significantly greater again at the .01 levels for physicians who in the first audit had been in the upper third of costs.

A study from Toledo compared hospital charges for common diagnostic tests by two groups of medical residents, one of which was exposed to an educational program on charges for the tests. Charges for ancillary tests and procedures were 25% lower in the experimental group, although the length of hospital stay and root charges were similar.

That physicians and medical students tend to be unaware of charges for diagnostic tests has been well known. Thus, educating physicians about medical costs may be a strategy to consider in implementing cost containment programs.

The eighth factor in Table 1 is participation in medical teaching. The extent to which practicing in an educational setting influences the cost of medical care seems answerable by two straightforward processes of cost accounting. First, what proportion of the hospital budget is attributable to patient care or teaching activities of clinical faculty? And second, to what extent does the teaching process alter the process of care, such as, by increasing the length of stay or increasing the use of consultative and diagnostic services such as laboratory and x-ray tests?

However, the question is made a great deal more difficult by the problem of case mix. That is, most university hospitals care for an unusually large percentage of relatively complicated patients or provide special services such as renal transplantation. The inability to control effectively for case mix has flawed most attempts to measure hospital teaching costs. There is also the problem of separating the joint costs that occur when teaching and patient care take

place in the same setting. I won't even get into that one, but getting back to the case mix issue, I think there is some interesting work that has been done.

Paul Griner at the University of Rochester has found specific patterns of laboratory overuse, patterns that he can document by clinical criteria, most dramatic being the use of blood chemistry tests.

In a follow-up study he compared expenditures for patients with acute pulmonary edema before and after the opening of an intensive care unit. While the mortality rate did not change, duration of hospitalization increased by 2.3 days and expenditures increased by 50%. Particularly striking were increases in lab tests, especially arterial blood gases, which showed a seven-fold increase in frequency coincident with the opening of the intensive care unit and probably reflected specific protocols where patients were routinely given these tests.

Two investigators from the VA Hospital at Duke judged lab tests for patients on the medical service on the basis of four criteria: Did the test generate an order for medication or the need for other care? Were the results considered in planning for subsequent patient care? If abnormal, was the test repeated appropriately? If normal, was it evident that the test ruled out diagnostic considerations?

They looked at lab tests on fifty randomly selected patients and showed that only 5% of the lab tests yielded a positive answer to any of those four questions.

They then did something which one can do in a VA setting. They arbitrarily limited the house staff to eight tests per patient per day. Following that maneuver, the percentage of appropriate lab tests increased from 5% to 23%.

We compared the experience of 450 hospitalized patients of thirteen faculty internists at two hospitals—one a major medical center and the other a nearby community hospital. The physicians hospitalized jointly at these two settings, thereby getting over the methodological problem that you may be testing for differences among the referring physicians.

We controlled for type and severity of illness and found that the duration of hospital stay was equivalent at the two hospitals, a finding contrary to the common wisdom that patients stay longer in university hospitals. I think this is some evidence, although it has to be verified in other settings, that when you control for case mix, duration of hospital stay is not longer in teaching hospitals.

We did find that frequency of consultations,

laboratory tests and x-ray was significantly higher at the university hospital. The increased frequency of lab testing accounted for 56% of the differences in the patient bills between the two hospitals. I think we can say that it appears that the teaching setting is associated with increased laboratory use.

Table 3 contains a summary of this section according to my subjective estimates of the evidence. I have rated each factor from one to four-plus, and this again is my boiling down of the evidence, my own personal experience and thoughts about it.

Table 3

Summary of Evidence Regarding Factors Influencing Physician Behavior in Use of Clinical Resources

Factor	Summary of Evidence
1. Improve quality	±
2. Patient demand	++
3. Fear of malpractice suits	++
4. Fiscal incentives	++++
5. Practice variables	
Group vs. Solo	++
Specialty	+
Prepayment vs. Fee-for-Service	++++
6. Educational background	±
7. Knowledge of medical costs	++
8. Medical teaching	+++

I don't think there is much data that physicians improve the quality with increased use of resources, although I think that is a very strong motivating factor. There is some data on patient demand and some data on fear of malpractice. There is good data that fiscal incentives—the whole reimbursement system—is a major, major factor for why medical services are used.

As to practice variables, it looks to me as if (again contrary to popular conventional wisdom of the Thirties, Forties and Fifties which said that economies of scale would result from group practice) these economies all relate back to the physicians, and that in fact, group practices probably are more expensive to the society than are solo practices.

There seems to be some relationship between specialty and cost. There is clear evidence—unequivocal, I think—that group prepayment will result in lower costs of medical care. There doesn't seem to be much data to relate to educational

background, some about knowledge of medical costs, even more about medical teaching.

Can physician behavior be changed? Implicit in this discussion is the assumption that physician behavior in the use of medical resources is susceptible to change. Some data are available to support this assumption. Three recent studies document a decrease in the use of medical resources after the institution of surveillance programs associated with feedback of the information to physicians.

For example, tonsillectomy rates in Vermont declined by 46% over a four-year period following feedback of data showing regional variations in that operation.

In 1970, the College of Physicians and Surgeons in the Province of Saskatchewan appointed a committee to investigate rapid rises in the provincial hysterectomy rate. There was some urgency to the committee because there might not be any uteruses left in the province if they didn't take some action! The committee compiled a list of indications for this procedure and classified hysterectomies as either justified or unjustified. The number of hysterectomies dropped by 33% subsequent to the review process, and the proportion of unjustified hysterectomies according to specified criteria decreased from 24% at the time of the first review to 8%.

The second study is a peer review system examining the usage and appropriateness of antibiotics prescribed for New Mexico Medicaid recipients. This was linked with programs to educate the physician population and to deny payment for inappropriate use of antibiotics. This system resulted in more appropriate use of antibiotics and reduced the use of injections by 60%.

I think that was a very important study. Just as kind of a tangential point, it is interesting in reading this very elegant study, which consumed a 100-page supplement to the journal, *Medical Care*, that not once did they deal with what I felt was the main reason why the shots were given—which is that Medicaid reimburses at a much higher level for that. Medicaid generally does not reimburse at full charges for physicians, and this is one way the physician could change the mix of his bundle of services and thereby generate more revenue. I have heard through the grapevine that the result of the decrease by physicians in the use of injections has been an increase in the use of laboratory tests.

Studies from smaller group settings show conflicting results. Freeborn and his colleagues

showed that physician lab use declines with length of employment at the Portland Kaiser program, and that the lab use profiles of the clinic chief set the patterns for other physicians. I think there is evidence for this: We demonstrated a 29% decrease in lab use charges after circulation of our medical audit.

The group from Toledo showed an educational program in medical costs led to a 25% decrease in lab charges by medical residents. On the other hand, a group at the University of Pennsylvania and a group at Stanford were not able to change laboratory use patterns of medical house officers by feedback audit systems concentrating on the appropriate use of laboratory tests.

One interpretation of why those two studies didn't work is that the patterns of the lab use, particularly in hospitals, are so strongly reinforced by existing incentives that programs by junior level faculty are not liable to overcome those powerful sets of incentives.

On the balance, it does appear that physician behavior is susceptible to modification, but not much is known about either the impact or the side effects of the various strategies to change that behavior. The importance of understanding and modifying physician behavior suggests a need for more research support from those with a stake in cost control, especially the federal government, other third party payers such as Blue Cross-Blue Shield, and concerned parties including medical and hospital associations, labor and management.

What are we to make of all this? I think the most obvious conclusion is that we need to know more about how physicians behave, how their behavior might be changed, and what consequences would result from such changes.

Unfortunately, because of the current political urgency as it relates to cost control and the likely complexity of research in physician behavior, we are probably going to have a set of actions that will not await this full understanding. In fact, that is really what a lot of policy is all about: action in the face of uncertainty.

In light of what we currently know about physician behavior, what strategies seem most applicable at this time? It is tempting in this setting to simply say that further research needs to be done, but I think I will go out on a limb and tell you where I think we ought to go from my perspective.

The first area I think we need to consider is

physician supply. Like hospitals, the doctors are seldom idle.

Ginzberg estimates that the net addition of one physician adds approximately \$250,000 to the annual operating cost of the health care enterprise. It is also likely that specialists generate more costs than generalists. As Reinhardt has noted, physicians have the capacity to generate sufficient demand so as to meet targeted income levels. Clearly then, adjusting the number and type of physicians produced would be an important and effective step in medical cost control. However, this move would not be popular politically and might affect adversely access to care in under-served areas. Furthermore, the long lag time required for physician training limits the usefulness of this strategy.

The second strategy would be to alter the fiscal incentives created by our current group of service reimbursement systems. If these built-in incentives are not changed, and if one assumes that the individual physician will continue to be able to allocate medical

resources based on his or her own judgment, then it seems less likely, in my opinion, that any other cost containment mechanism will be very successful.

Other strategies short of these two fundamental reforms are liable to be less controversial as well as less successful. Still, encouraging the growth of prepaid group practices continues to be an important approach to cost control, as does educating the public and the physicians about the nature and extent of medical costs.

Some experimental ways of requiring second opinions for surgery that is not urgent have resulted in lower surgical rates. Utilization review, while not producing dramatic results, may be one of the factors that has resulted in the national decrease in hospital occupancy and the decrease in length of hospital stay. But in the long run, cost control is really a social issue whose resolution depends on a broad level of consensus about the appropriate level of medical expenditures in our society. I hope that many of you will be working to help clarify that issue.

DISCUSSION

with Steven Schroeder

CHAIRMAN ANDERSEN: As an outsider looking in it seems to me the administrator does have many opportunities to use his steering wheel as well as his brakes.

We do have just a few minutes for discussion, so if you have questions for Dr. Schroeder, we will take them now.

MR. WESLEY ENNIS: Dr. Schroeder, you mentioned several educational activities that later had impact on behavior. Do you have a feel for how much of that change of behavior might have been due to a Hawthorne effect? Have you run any tests to see if that behavior continued for any length of time?

DR. SCHROEDER: That is a good point, and the problem is that the settings from which most of those came had physician instability. They were training programs or centers where people were rotating, and it was impossible in most of the studies we did to keep the group stable. That is one of the problems with health services research, you can't isolate all the variables. The answer is no. I suspect part of it is Hawthorne. How much is Hawthorne and how much is the effect of the education is unclear.

The point I wanted to make is that unless you

change the incentives, I am afraid that you are not going to make much of a dent with that kind of voluntary program.

DR. EVERETT A. JOHNSON: I would like to make a comment and get your reaction. In a lot of your material you were referring to laboratory use. In a hospital laboratory if there is a high degree of automatic analytical instrumentation being used, it doesn't matter much if there is repeat testing. The common pattern that you find in a lot of laboratories is that they will get an initial SMA12-60, and the next day or the day after they are going to want one or two more tests.

The laboratory runs these on two-channel or four-channel analyzers. It is stupid. It costs only ten cents or fifteen cents to run it on the whole works. With 75 to 80% of your total laboratory volume in chemistry and hematology, which is where the high volume instrumentation is, what I think you are really looking at is the pricing policy of the hospital. Hospitals have not, by and large, looked at the fact that they are really making all the big bucks in the laboratory in chemistry and hematology and maybe losing it in the other laboratory services.

So if you are looking at charges in terms of a hospital laboratory, it doesn't make a great deal of sense. It shows up on the bill, so what we need to do is not to stop the use of the testing, but to change around the rate structure of the laboratory.

One other observation along this line. If the use of laboratories is really insignificant in a cost picture, one of the things we ought to barrel in on is the use of consultants to attending physicians. That's a very expensive process. A lot of it reflects the inadequacy of a guy and the refusal of a medical staff to step up and do something more than just load it on to the patient by telling him he has to have consultant on top of consultant.

Finally, the last observation in terms of test procedures in hospitals: my experience has been that the younger physicians use a lot more tests. The senior physicians use fewer tests initially until they get to obscure diagnoses, and then they really use a lot of testing. I noticed that in your material you did not include the criteria or the function of age of the physician ordering the test.

DR. SCHROEDER: I agree with all that you have said, but I would like to comment on the whole issue of cost centers. The difference between charges and costs is a critical one.

The hospital is as flexible as the physician in responding to the way things are, and that is how you are paying for social work. My fear is that if you really cost things out accurately, then given our pricing system, the things that are going to go are the soft social services that are humane, the patient education, the child care, the social work, the rehabilitation, because they don't pay very well. So I think just to say, "Let's have cost centers, and let's only charge ten cents for the SMA," which is what it costs, will reduce the hospital bill which will reduce the hospital revenue that is received, and it will cut your budget back, but you will then have a problem of how you cut bootlegging other services off of those.

But I concur that our pricing system ought to be looked at very carefully. I think it is very complex, and I think one has to look at what the internal tradeoffs are and what the constraints of the third party agencies that look at this are.

I think this group really knows more about that than I know.

DR. JOHNSON: One other point. The use of drug therapy many times is dictated by the fact that the physician has knowledge of insurance policies, and he

is using it to justify to the insurance company what has gone on with the patient.

DR. SCHROEDER: Your second point is the accountability and discipline of physicians. I think that is very important, very complicated, because those cases where the medical staff tries to discipline a member and take away privileges gets into due process litigation. So again it makes a lot of sense. It is important, but it's not very easy to do. I think we are incrementally getting toward that, but it is very difficult.

You mentioned the issue of the age of the physician and the diffusion of new technologies. The studies that have looked at it from, say, Kaiser-Portland and our studies, and there are not very many, do not substantiate your point, but I think you are right. I think the studies just haven't been broad enough.

When you look at the diffusion of new technologies, they tend to come in at the academic medical centers and spread out and set practice patterns. So again I think age is almost incidental. I think we have to look at the incentives that reflect how new technologies get used, what inhibits them, what promotes them. Virtually all of the incentives do promote them, and I think that is again a complicated issue.

MR. HOWARD GREENWALD: I want to follow up a little bit on the last question. You presented the various correlates in a cross-sectional sense. I was just wondering if you have had any judgment about what the historical trend would look like in terms of laboratory use.

What I have in mind is that perhaps the one thing that helps explain laboratory use might be a long-term tendency for both the educational process and related to that, the judgment by physicians about what would produce good care, to have more and more to do with the quantitative, specific type of judgment rather than a clinical judgment. Now this type of thing which might be a long-term trend might be a little bit more difficult to manipulate through the incentive system. The question is more a matter of policy than an academic matter.

If, in fact, this tendency is a factor in producing a long-term reliance on quantitative data that come from laboratory tests, how can you affect it through incentives?

DR. SCHROEDER: The answer to your first question is yes, there are data. The data show that an increasing

portion of medical expenditures are related to laboratory tests.

The net addition of a laboratory test tends to be on balance additive rather than substitutive. For example, when a CAT scan comes in, it is added on to all the other diagnostic procedures.

What are the different factors that urge quantification? I think I tried to list some of them. It is

complicated, but I think again if you look at the incentives from the physician's point of view, there are no cost deterrents. There are no cost deterrents to doing that extra thing. The hospital is now being asked to contain costs and to budget prospectively. The physician isn't being asked to do that yet, at least, in most centers.

What a Hospital Administrator Has Done to Contain Costs

LAD GRAPSKI

CHAIRMAN ANDERSEN: Our second speaker is Lad Grapski, President of Allegheny General Hospital in Pittsburgh. Lad told me that he has a subtitle which is "How to not only control the administrative brakes but the steering wheel as well."

MR. LAD GRAPSKI: Good morning.
During this symposium:

1. I've heard management concepts and principles which may be theory now, but which could be the tools leading to greater cost effectiveness in the future.
2. I've jotted down some ideas which we all look for at meetings like this; ideas that we can start putting into practice on Monday morning when we open shop.
3. I've sensed some underlying philosophies, some of which I already believe in, and some of which I don't really understand.

I'd like to organize my remarks in about the same way, that is, some managerial philosophy to get things rolling; a number of productive cost containment ideas which we have found to be successful; and finally, some concepts which hold great promise.

COST CONTAINMENT PHILOSOPHY

Cost containment is not a new concept to hospital administrators, each of us having for years faced the cold realities of having limited resources to meet unlimited needs. The concept of cost containment also is not unique to the health care industry. For instance, examples of similar efforts could be cited in the steel industry, the transportation industry, etc. There is, however, at least one major distinction between the cost containment efforts of these other industries and of the health care industry, that being the *direct* relationship which these efforts have to the present and future of the population.

Cost containment, from the administrator's point of view, is maintaining the relative quality of services being provided while simultaneously attempting to hold the rate of expenditure to the minimum. In today's well run hospital, however, the ability of an

administrator to contain costs is somewhat limited, since nearly every such effort has a direct or an indirect effect on the quality and/or the quantity of services being provided. The job of the administrator, therefore, is to work with his or her physicians and trustees to identify areas in which the containment of costs will have the least detrimental impact on the services being rendered to the patients.

Cost containment is here to stay. Nationally, I hear a call for creative cost containment philosophies being raised by the leaders of our industry. Alex McMahon said recently: "The heroes of yesterday were the expansionists, the heroes of tomorrow will be those showing the way to make do with less."

"Doing with less—gracefully," was the whimsical headline of Bob Cathcart's recent article in *Trustee*. I am also reminded at this point of the theme of our Eighteenth Annual Symposium: "Survival In Utopia."

COST CONTAINMENT EXPERIENCES

Turning to actual experiences, I should point out that the setting for these cost containment ideas is the Allegheny General Hospital, a 726-bed regional teaching hospital located in the city of Pittsburgh, Pennsylvania. Being located in Western Pennsylvania with its lack of any public, acute-care general hospitals, presents us with some rather unique problems which include:

1. A high incidence of free care and/or bad debts. This leads to a bottom line cost to our hospital in excess of \$885,000 per year.
2. The necessity to subsidize services rendered on an outpatient basis to Medical Assistance recipients as well as the near-poor. The Commonwealth of Pennsylvania pays a fixed fee of \$12.00 per outpatient visit, while our actual cost for this service is \$38.00. This results in an annual loss to the hospital of approximately \$825,000 per year.

Allegheny General Hospital maintains major teaching programs, research activities and sophisticated tertiary services, all of which require a significant investment in technology, facilities and staff. As an urban hospital, there is a commitment to provide extensive ambulatory services in response to the many

complex, socio-economic and health problems of the area.

All of these conditions, plus the need to finance a new hospital facility, have necessitated that the board of trustees, the physicians and the management of Allegheny General Hospital work cooperatively and constantly to strive toward a break-even or a marginal operating surplus position.

Annually, the revenue producing areas of the hospital are analyzed through utilization of a computerized financial model to determine their contribution towards profit at both a direct and indirect cost level. Unfortunately, most of the unprofitable areas fall in the ambulatory care services such as the emergency room, clinics, family planning, outreach programs, dental, pediatrics, speech and audiology, and obstetrics.

Once the unprofitable areas are identified, they then become the target of a combined effort to improve profitability on the part of the board, the clinicians and the management. In recent years this has resulted in the hospital achieving a near break-even situation.

Some of the methods of cost containment which we have found to be most effective include:

1. Re-negotiation of professional contracts to reduce base salaries or to underwrite an increased portion of professional compensation through fee income. This resulted in hospital savings of more than half a million dollars in one recent year.

2. The reduction of excess malpractice coverage to a minimum (\$2,000,000 vs. \$5,000,000).

3. Reduction of bad debts through steps such as: pre-admission financial screening, advance deposits, and increased collection efforts.

4. Yesterday you heard from Howard Gindele the prospective reimbursement system that we have for Blue Cross, Medicare and medical system payers. This has also been a stimulus to the hospital's cost containment effort. Prospective reimbursement programs tend to force management and clinicians to become better managers and to operate within predetermined cost limits. As we know, under the traditional retrospective system no such incentive exists. In prospective reimbursement there is an incentive to share in cost savings to the extent of fifty cents on the dollar. In the last year which has been completely audited, this savings amounted to \$233,000 in additional revenue for the hospital.

5. Another successful cost containment idea has been the operation of a forms management program which reduced the hospital's forms and printing costs

by over \$50,000 per year.

6. Utilization of telephone and utility consultants to monitor utility bills has resulted in additional cost savings for the hospital.

7. Stricter supervision of employees during probationary period, with positive sign-off by supervisory staff is another idea worth consideration.

8. The conversion of deficit hospital outpatient services to private practice services may be worth exploring for your hospital. In one department of Allegheny General Hospital, this resulted in an annual hospital savings of \$101,000. Now we are looking at all the other various services we have within the hospital.

9. One of our more successful programs has been the maximization of investment income by use of a cash management program that includes: cash flow forecasting, zero balance accounts, use of float, and delaying payment of accounts payable. Today we are at 120 days unless significant discounts are given.

10. Allegheny General Hospital also has instituted an extensive risk management program, which has resulted in a 5% reduction in insurance premiums to the hospital.

11. Through our cost containment efforts we have attempted to get the maximum utilization of sophisticated management reporting systems that highlight unfavorable variances from budget, both in costs and in productivity of personnel.

12. The utilization of such personnel as nurse practitioners to reduce the number of higher skilled (and higher paid) employees has also been tried. This has proved successful in our emergency room, our primary care centers and so forth.

13. In this day of litigation, rather than rely on outside counsels when problems arise, we now have an internal legal counsel. This is saving us a significant number of dollars each year.

14. Another cost saving idea is the use of ten-hour, four-day work week scheduling in some departments. This eliminates split shifts and reduces the number of aggregate hours worked.

15. The hospital has continued to seek grants and contracts to cover some existing costs.

16. Last, but not least, we have expanded the Northwest Allegheny Home Care Program, which provides for earlier discharge from the hospital, thus reducing utilization review denials to the institution.

The cost ideas just presented are operationally oriented, but for those of you in the midst of facility change, another set of cost ideas also merits attention.

In 1969, Allegheny General began a replacement

program which by 1982 will see most of our major buildings replaced. The local Health Systems Agency has stated that the approved Allegheny General Hospital project of \$104 million is the only one in the Pittsburgh area with operating cost savings built in from the ground up.

In planning for a new facility, our experience would indicate that such cost savings ideas be considered as:

1. A reduction in personnel costs in new structures by full use of the state-of-the-art application of automation.

2. Minimization of future utility costs through the use of the proper sun orientation, shading factors, insulation, window placement, etc.

3. Full use of every available technique to maximize the return from the building fund development drive so as to reduce the amount of construction to be financed.

4. Use of discretionary hospital monies throughout the construction and financing periods of the new facility, to minimize capitalized interest.

5. Funding the debt service reserve fund using available board-restricted funds to reduce the amount to be borrowed, and therefore future interest expense. This procedure also takes advantage of the current Medicare regulations and maximizes the hospital's reimbursement in future years. In our instance, for example, this is a fund of \$6.2 million which, over a twenty-year period, will give us additional cash flow of an additional \$23 million.

6. Use of short-term, tax-free construction loans to minimize construction interest, and therefore future depreciation. Also, the creation of a time window for permanent financing so as to select the optimum market time for the sale of tax-free bonds, thus reducing the average interest rate on the indentures.

STRATEGIC CONCEPTS FOR COST EFFECTIVENESS

Were this a hospital trade association meeting instead of an academic meeting, or were I twenty years younger, I could well thank you for your time at this point and sit down.

However, my experience warns me that while the many practical things that I have mentioned may satisfy the less mature hospital manager, in the long run they will not be sufficient to achieve the necessary level of cost control which will be required in the industry. This means that we must try new things, new approaches, new ideas if we are to survive as a voluntary health care system.

WHAT A HOSPITAL ADMINISTRATOR HAS DONE TO CONTAIN COSTS

DIVESTMENT STRATEGIES

Looking to the future, there are a number of different strategies which an administrator can employ to contain hospital costs. Without question, total program or department cancellation offers the swiftest results in saved dollars. Allegheny General Hospital experienced this divestment challenge in activities such as dental education and in child care programs when federal funding ceased several years ago. Because it is a very difficult task to "shut down" desired activities, and I can speak to that personally, there can only be one rationale, and that is to prune a small part swiftly, without hesitation, to assure the health of the larger part.

CORPORATE SPIN-OFFS

Closely allied to divestment is the notion of spinning off (out of the hospital corporation) programs into another controlled organizational setting, such as a subsidiary corporation.

These are activities and programs which are still essential to the hospital, but which could be removed from the hospital structure, thereby permitting the dollars to be used elsewhere.

A prime example of such an activity is that of research. As an illustration, on July 1, 1977, we created a parent corporation, of which I am President, the Allegheny Health, Education and Research Corporation. Simultaneously, we created two initial subsidiaries, the first being the Allegheny General Hospital, and the second being the Allegheny-Singer Research Corporation. All research costs of the hospital subsequently were transferred to the research subsidiary. Although this reorganization did not significantly reduce the cost of conducting biomedical research, it did, however, give greater visibility to these research activities. This has enabled us to solicit additional outside funding to support research activities, and thus reduce the level of necessary hospital support.

Another example of a corporate spin-off is in the area of services which have the potential for serving multiple institutions. Everyone is well aware of shared projects such as joint laundries, and Allegheny General Hospital is a co-owner of a shared laundry. Of course, we still pay for the linen whether we do it ourselves or buy it from a shared facility. Over the long term, however, specialized management and economies of

scale should ensure the lowest possible costs for a volume function such as a laundry.

PARTNERSHIP STRATEGY

A third strategy for cost containment which might be considered, is that of the partnership strategy. This strategy is based on the principle that while we might like to own and control every aspect of the health care delivery system, external conditions nevertheless necessitate that we reevaluate such a desire and consider going into ventures with others.

To illustrate, we granted a ground lease to the private developer of our professional office building. While maintaining control of the activity, we also gained cash flow and better utilized the hospital's scarce funds. This facility is fully integrated with the hospital and the parking garage, and is a splendid example of a partnership strategy.

MARKETING STRATEGY

The last strategy which I would like to discuss involves several ideas from health care marketing, which you and I have been doing for many years, even though we did not refer to these activities as marketing at that time.

Obviously, marketing can be designed to produce many results, of which cost containment is but one. For example, the Allegheny General Hospital several years ago began segmenting its markets into more logical and relevant units. As you know, for many years we have, in this industry, segmented pediatrics and obstetrics, and related specific services to these market segments with excellent results.

The Allegheny General Hospital Board of Directors, after careful market research, elected to put its primary resources in the fields of cancer, heart and aging. To illustrate the potential cost savings to be derived from the application of marketing skills in health care, in cancer we obtained and have on computer about 140,000 abstracts of cancer patients in the Western Pennsylvania area. This computer market model is now permitting us to analyze the kinds of cancer, the types of treatment, the location of residence

and treatment, and many other things. On the other hand, we are aware of our clinical resources, and thus we hope to be able to select those segments of the cancer market for which our resources can do the best job. You might say we are directing our resources to very precise segments of the market.

We believe that there are significant cost implications in being able to selectively address specific market segments that can be most effectively served, and conversely, that there is equally great cost value and value to the patient of not attempting to provide services to segments of the cancer market which others are already serving. In other words, instead of trying to do everything for everyone, in the future we may all want to narrow down to those we can best serve—which in turn will result in our most effective utilization of our available resources.

SUMMARY

In summary, we have:

- 1) thought about some basic philosophies concerning cost containment,
- 2) heard some practical examples of what one administrator has tried to do to contain hospital costs, and
- 3) reviewed some concepts which may prove useful in the future.

Naturally, the implementation of any of these ideas requires the full understanding and support of all members of the health care team, be they housekeepers, nurses, physicians, administrators or trustees.

I hope that you believe as I do in a well conceived cost containment philosophy, i.e. a philosophy which results in a program aggressively and innovatively implemented by trustees, clinicians and managers; a program which utilizes the methodologies of corporate planning, marketing, finance, etc. Such an approach will successfully meet Odin Anderson's challenge to "do more with less."

PANEL DISCUSSION

Henry P. Russe, David L. Everhart, Everett A. Johnson, Lad Grapski

Moderator: Ronald Andersen

CHAIRMAN ANDERSEN: For our panel discussion, each of the panelists will speak ten to fifteen minutes, and then there will be time for some questions. I also asked Lad Grapski to join us for any response.

Our first panel speaker is Dr. Henry Russe, Chief of Staff, University of Chicago Medical Center. We are very pleased to have him join us.

DR. HENRY RUSSE: I should explain a little bit about who I am. I don't know very many of you in the room. I am a product of the University of Chicago Medical School, and my clinical training as an internist was at the University of Chicago.

I was on the faculty here for a number of years before I left in 1968 to go to a group of community hospitals in Chicago which were in the process of changing their image, coming into the twentieth century. Columbus, Cuneo and Cabrini Hospitals, owned by the same order of nuns, had decided that in 1967 they ought to consolidate. Over the space of the next several years they formed a medical center which is now a 1300-bed complex.

I was the Chief of Medicine there, and very quickly, because of nosiness and interest—and also self-preservation, as I was trying to build the Department of Medicine along the lines of the one I had left at the University of Chicago—I became at first a gadfly in the administration and ultimately insinuated myself into the administration. When I left there, I was Vice President for Medicine for the corporate group and a member of the joint management team. I learned a lot of new tricks.

I have been back at the University of Chicago for the last couple of years as one of the people in the Dean's office responsible for clinical activities, and have had a great deal to do with hospital management as well as physician governance and the interaction between these two. I suspect that may have something to do with Odin's invitation to me to speak on the panel.

It has been an interesting time. As you know, we are still in a state of reorganizational flux, and I will not

make any specific comments on that. I think we are doing what lots of places do as there is a change in leadership. We have had the interesting experience of having three Deans in a space of about a year and four months. I thought the comments of the speakers this morning were very interesting. I wish I had brought with me a reprint of an article that I published in 1969 in the *Medical Clinics of North America* when, by invitation from Peter Talso, now Medical Director of Little Company of Mary, I was given the assignment of writing a chapter called, "The Use and Abuse of Laboratory Tests." I didn't know a great deal about it, but I went to the literature. At that time, the literature wasn't as extensive as it is now.

Many of the comments that were made by Steve Schroeder emphasized the little that there was in the literature at that time about the use of laboratory tests. You might be interested to know that the concern in the mid-Sixties was largely on the East Coast where automated chemical devices made their first appearance. The *New England Journal of Medicine* was replete with articles about this in letters to the editor.

I began that 1969 article with a paraphrase of Sir William Osler. Osler was one of the great gods of clinical medicine in this country at the turn of the century. He was a physician in private practice who had an extremely lucrative practice, and I suspect the profit motive might be one that guided his activities. He was also a person who was aware of the fact that people had a great need to take drugs, and he is credited with the statement that man's significant difference from the monkey was that men needed to take drugs more often than monkeys did. I paraphrased that by saying that physicians had a need to order laboratory tests which differentiated them from other primates.

At that time the automated chemical devices were making it possible for physicians to order a series of tests, multi-channel tests, on their patients. The initial novelty of this, I suspect, attracted a great deal of attention. It was at that time possible to selectively order these tests, a far cry from what we now see when

the patient who comes in to the hospital automatically has a sixteen- or a nineteen-channel (depending upon the various machines employed) diagnostic study before the first question has been asked.

At our own institution, in the admitting process, once the bed is assigned, the patient is processed through the hematology laboratory and through radiology and through the heart station automatically and is given about \$318 worth of diagnostic studies before the intern even takes a history. This does speed things up, and it saves bed days and is probably a manner of cost containment, one might say.

I was interested to hear Dr. Schroeder's comments on the modification of physician behavior. I would agree with his premise that this is probably a very appropriate place to start. I would like to share with you a couple of brief experiences in an attempt to do that, only as examples, perhaps, for some questions from the audience later.

We have recently finished a very carefully designed, and I would think, accurate study of antibiotics usage of one particular group in our medical center at the University of Chicago Hospital, the cephalosporins. These are semi-synthetic antibacterials manufactured now by several drug houses that all have a similar spectrum of activity. They all have similar use indications, and they all cost money. Some of them cost a great deal more than others.

Our antibiotic usage audit done recently by the hospital epidemiologist and his crew, with support from computer-assisted data analysis, has suggested that for the same basic diseases, we are over-prescribing this group of drugs for probably 30% of our patients. The interesting thing is that as the study proceeded, it was apparent that there is one specific manufacturer whose cephalosporin costs about four and a half times what the lowest-priced agent costs, while the efficacy of the two drugs is virtually identical.

We actually went back and looked at the culture isolates from these patients who had been treated with the cephalosporins in the preceding three- to six-month period, and those that were still in stock and in our micro lab. This is usually the case. They are kept for quite a while.

We did drug efficacy studies on the specific strain isolated from the patient with the different cephalosporins, and we found that with the exception of less than .05% of the culture isolates, the lower priced drug was effective.

We had a meeting of the Pharmacy and Therapeutics Committee after the hospital

epidemiologist had presented this information to me and to the budget group with the idea in mind of displaying it before that committee and getting their endorsement to remove the more expensive cephalosporin from our formulary.

The drug study group reported their findings. The Committee on Pharmacy and Therapeutics took this information back to their constituency, and interestingly enough, in one of the departments which happened to be surgery, the response was totally negative.

One of the senior surgeons felt that brand X was the only brand that worked, and when we looked at why this senior surgeon felt that brand X was the only brand that worked, it was possibly because this surgeon had a habit on Monday after surgery of having coffee with the detail man from the firm that manufactured brand X. There was no collusion. It was just a habit pattern. They had been having coffee together for years.

When we pointed this out to the surgeon, he said unprintable things, and it looks like our Pharmacy and Therapeutics Committee is going to recommend that in specific cases where the individual physician can document the efficacy of that drug, brand X over brand Y, our formulary will allow him to use that. This is a part of the democratic process.

It is amplified in all of your hospitals, I know. It is particularly pointed in ours because if we would limit our cephalosporin use to only brand Y, which we know is every bit as efficacious, we would save about \$186,000 a year in pharmacy costs at the front end to say nothing about probably providing the same quality of patient care, and I presume that is excellent.

This matter was the subject of a symposium at the recent meeting of the College of Physicians in Boston chaired by Henry Simmons, a former commissioner of the Food and Drug Administration. The title was "Jet Powered Snake Oil Promotion."

This was a symposium that had a very distinguished group of panelists including Franz Ingelfinger, the former editor of the *New England Journal of Medicine*. Their premise was that many of the prescribing habits of this country are not really a product of age, or of group versus solo, or of educational background or training experience, but rather the result of the fact that the pharmaceutical industry spends billions of dollars (\$2.7 billion in the years that they discussed, as I recall, for the promotion of brand X).

I think this is one of the things that we can look at as

an avenue for cost containment with a little bit more effective education of the physicians, but I don't think that it will come at the hands of the drug houses.

Unfortunately, we weren't able to hear the whole panel because forty-five minutes through the presentation there was a bomb threat, and the hotel was cleared. I don't know what the decisions would have been.

So I would only second the comment of Dr. Schroeder about the need to focus on the group of people who are helping to spend the dollars.

In our institution here and at the institution I was with previously, our experience is that we are always paying for something more than we are receiving. Certainly with the unfunded patient population that one sees in a large urban hospital, this dollar drain amounts to million dollar levels.

In our own institution we have no problem complying with the Hill-Burton requirements for free care. I am sure that is true of all of you. We calculated that last year we exceeded it sixteen-fold, but we have to provide these services because the patients present themselves, and this cost needs to be covered. So we pick it up with our ancillaries. Although we are not as fortunate as some of the hospitals on the Atlantic seacoast that are being charge-reimbursed rather than cost-reimbursed, we all have imaginative ways to fold these things in so we can afford to have a social service department and so on.

I will turn now to the comments made by Mr. Grapski and raise a couple of considerations. One of the suggestions for cost containment was the decrease in the malpractice coverage to \$2 million from \$5 million. I think this is something that would certainly be useful depending on the locale.

In our own institution where we are self-insured, we settled \$3 million last year, and we went to court over several others. Our total malpractice expenditure last year alone was well in excess of \$3 million.

I would wonder at the utility of taking only a \$5 million exposure limit, but I suppose the university hospital associated with what people presume to be a huge endowment needs to be more careful. Our present coverage limits are \$45 million. We are now under suit in class action and other suits for a drug study done in 1952 at a time when the malpractice coverage was about \$50,000 with a \$10,000 deductible, and in the aggregate we are being sued for over \$141 million. These suits have not yet come to court. Through judicious use of extra dollars for legal fees, we are maneuvering.

**PANEL DISCUSSION WITH RUSSE, EVERHART,
JOHNSON, GRAPSKI**

I think that many of the comments made by Mr. Grapski describe things that some of us have done or have been doing or have thought about, and unfortunately, a substantial number of them again involve the doctor.

It has been an interesting experience for me to have made the transition from them to us, and we to they, as I have moved back and forth, in and out of hospital management, and still continue to be a practicing physician. I think many of the cost containment things that can be done in a hospital setting have to be done with the senior physicians, or at least those who influence the opinions of the physician group heavily involved in the design process, so that when implementation is essential, they can be helpful.

I think those comments will be a base for my answers to any questions.

CHAIRMAN ANDERSEN: The second panelist is David L. Everhart, President of Northwestern Memorial Hospital. We appreciate your coming down from the North Side.

MR. DAVID L. EVERHART: I appreciate being invited to come down to the South Side. As a matter of fact, I feel honored to be admitted into the inner sanctum of the University of Chicago. I am a Columbia graduate. I spent fifteen years on the East Coast and am on the Near North Side now, so this is very pleasant. I appreciate being here, although I must say that as I look across the audience, some of my best friends who were here yesterday and last night, people like Irv Wilmot and George Bugbee and Don Shropshire and even a guy that is on my own staff, McNary, don't seem to be here this morning. I am not sure there is any significance to that.

Secondly, I would like to thank you for putting me where I am on the program because I have known Ev for a long time. I am glad to be able to say something before him because I recognize I wouldn't have a chance after him.

I have spent a very interesting week. Two and a half or three days of the week were spent at a meeting of the Council of Deans of the AAMC. I was there as a representative of the Council of Teaching Hospitals, and I think you might be interested in what the deans, over 100 of them assembled in Snow Bird, Utah, were

talking about. Their entire meeting covered the subject of the interface between government and academic medicine. There wasn't one paper or any time spent on student selection or curriculum, or research, or any of the things that deans normally are concerned with.

Instead, they spent all of their time on the relationship between federal and state policymakers and schools of medicine and deans. They had a session on the voluntary cost containment program in hospitals.

Dave Kinzer, whom a good many of you know, gave a speech on his attitudes about regulation. There were some show and tell sessions about what various medical schools are doing to improve their relationships with government and to improve their ability to influence legislation, so that the deans are concerned with the same kinds of problems that we are concerned with. I came away from that meeting with a feeling that things are indeed changing.

I was here just for part of yesterday and last evening and this morning, but it seems to me that those of you who are involved with the operation of health care facilities—and I assume there are quite a few of you in this room—those of us that are still involved on a day-to-day basis with this crazy business really do find ourselves in a Catch-22 situation now.

Traditionally, historically, we have been interested in the growth of our facilities and improvement of our programs and the quality of those programs; in new ideas; in providing ever-improved environments for quality of patient care services and quality of teaching; and in research. Somehow or other there is now a change in that emphasis, and we are interested in survival. We are interested in cutbacks. We are interested in the term used this morning "graceful retreat." We are interested in examining all kinds of new arrangements with other institutions that used to be competitive but are now all of a sudden our friends.

We have got a lot of strange bedfellows in terms of who we are and what kinds of decisions we are making. We are called on constantly to be better managers, to be more efficient, to reduce rates and costs and expenditures, but in the eyes of those who would regulate us and who measure the effectiveness of our management, there is a very open question about our integrity and a real question as to whether a black figure on the bottom line is conscionable.

We are called on increasingly to tend store, to stay home, and to pay attention to what is going on and to make those kinds of decisions that have to be made to be efficient and to be good management, but at the

same time, we increasingly have to be students of all kinds of involved political, social, economic theories and stratagems that are being tossed our way because another of our principal functions is to serve as the interpreter of those stratagems to our medical staffs and to our boards and to be sure that our institutions and the leadership of those institutions are informed, and are there and ready to respond properly when they have got to punch the right button or pull the right lever.

We are told in many ways and by an interesting assortment of people that our costs are too high and that they have got to be controlled or regulated, or that the rate of increase has to be reduced. Yet, we are also told that 88% of the people of this country are satisfied with the medical care they are receiving and that they really don't have any great concern about costs.

So it seems to me we really are in a Catch-22 situation, and there is no place where that is more obvious than where we, as administrators, or managers are being evaluated by our own boards or by the people to whom we are responsible.

We were just talking here before the meeting started. There is a big national debate about prospective rate review, whether it should be at the state level or the federal level. Five years ago there wasn't any question. It shouldn't have been in either place, and here we are as administrators and as managers helping to evolve mechanisms that are going to regulate us. We have got a prospective rate setting program, which has just about gone over all the hurdles in Illinois and is about to be enacted hopefully, and which will, in fact, create a prospective rate setting review program for Illinois which has never had one.

Some of my board members say, "You are out of your cotton pickin' mind to support that kind of a concept. If you are not regulated, why ask for that kind of regulation?" It is hard on occasion to explain why it is important to influence the nature of that regulation, but the fact is that it probably is inevitable and if you don't influence it, somebody else will; and the results will be much more deleterious.

We are talking about mandatory or voluntary cost containment and coming out hard and strong on these issues, so I think these are interesting times. I think those of us who are in management positions do find ourselves frequently in the very awkward position of being on both sides of the fence. Let me talk for a minute about some long-standing ideas I have about the role of the physician in this situation.

In the first place, although I haven't heard this really

referred to, the physician is not the enemy. The physician is somebody who has got to work with us and we have to be very responsive to his feelings. I think it is generally true that physicians by and large have not given the question of cost very much thought. They are generally naive about the question of costs and about programs, and therefore, I think that one of the lessons that all of us have learned over time—and now have to practice in increasing intensity—is the necessity for the involvement of the staff and the involvement of our physician leadership in the decision-making process in this era of “graceful retreat.”

Not only involvement, not only good communications, but commitment by that leadership is necessary, so that when an institution makes a decision concerning cost, it is something that is understood and agreed upon and supported by the physicians on the staff. I happen to agree that 80% of the costs generated in an institution are generated by physicians, and therefore, the importance of their involvement, I think, is obvious.

Secondly, all of us, in representing our institutions, should be constantly going through the process of re-examining the role and mission of the institution. I think more than ever we are going to have to look at the very basic issues of what we do best as a hospital, what is expected of us by the community we are serving, and what we do least well; we must be able to differentiate among these and accept the fact that there are occasional things that we don't do well and perhaps shouldn't try to do. That certainly relates to the issues that were being discussed on the demand side of the question.

What are the demands that are being made upon us by physicians with respect to laboratory tests or drugs or special procedures or new programs or new equipment, and what are the demands that are being made by the general public? How can we better control those demands that frequently we, as managers, don't really have a good handle on? I think that the whole question of role and mission—what we do best, what we do least well—is something that needs constant reassessment.

I think all of this relates directly to the budget process of our hospitals. I know I need not emphasize the importance of that process to this group, but the accuracy of the projection of the volume of patient activities and the loss leaders, the ones that are going to make the money and the ones that are going to cost money, obviously must involve the physician.

The simple projection of the days of care which is about as basic a figure as you can come up with in terms of budget projection, is one that is very difficult these days. With the increasing down trend in length of stay, the increasing amount of ambulatory care being rendered, the increased attention being paid to utilization review and PSRO and real questions on admissions, I think all of us are finding that the historical data upon which a lot of our budget process is based may or may not be sound. Therefore, the whole question of the accuracy of the budgeting process and the involvement of physicians and the commitment of physicians in that process is essential.

There is a whole other area that I will just touch on, and that is what we can do or what we should be doing in teaching hospitals to enhance the learning process of the young physician, to be concerned about quality, and be concerned about the eight points that Dr. Schroeder talked about this morning.

I had an interesting experience a few weeks ago. I testified before the Rogers Subcommittee on P.L. 93-641 on behalf of the AAMC. We inevitably got into the business of cost of care, and Rogers, in the course of conversation or cross-examination or whatever it is, asked me the extent to which medical schools in this country have any programs or any curriculum that is aimed at the undergraduate student that has to do with the economics of health care and specifically the whole question of how they, as young physicians coming into the system, are going to help reduce the cost of that care.

We did a very quick and dirty survey, and found that there is precious little in the way of discussion of this subject in the curriculum of undergraduate medical students. I think those of us in teaching institutions have a responsibility to mount this kind of a program with our house officers. It is a tough problem because again you are in a Catch-22 kind of a situation.

These graduates are generating revenues by the tests they order, and you are dependent upon those revenues, but at the same time, you know in your heart they probably don't need to order all that they are ordering. This all gets into the business of how you “retreat gracefully.”

Then finally, there is the whole issue of marketing—determining what people want and redesigning your programs around those needs rather than the General

Motors approach which is, what is best for them is best for the country. A good many of us in hospitals and a good many institutional physicians, I am afraid, have adopted this kind of credo.

These are some comments and perhaps they will stimulate some discussion.

CHAIRMAN ANDERSEN: Our last panelist is a substitute. We had really planned to have Bob Hope but he cancelled at the last minute. Actually, I am personally pleased to be able to introduce Ev not only as President of the Dunes Group, but also as Associate Director of our program.

DR. EVERETT A. JOHNSON: Ron, my first observation is back to friendly Dave. As he said, I have known him for a long time, and I have noticed in those two decades he hasn't changed one bit in appearance even though he has aged. The conclusion I draw is that he is rotting from the inside out.

What I would like to do is just simply give you some random thoughts I had, sitting and listening to the speakers yesterday and today. We have had several comments about the increasing cost consciousness of the physician. Dave just finished with that.

I have a little bit of a worry about that because there are a couple of guys in this room and myself that can go back far enough to remember when we raised hospital rates, the medical staff blew up because there wasn't that amount of coverage for the public.

If we get the physicians cost conscious, my guess is that their move is not going to be in the direction that has been described today, but the move will be back where it was twenty-five or thirty years ago. They are going to try again to control the hospital rate structure and we are then back into another Catch-22, so I think you had better take that one a little softly.

I have had the feeling that I have learned nothing new here, and I don't mean that in any way other than the fact that I think it represents exactly where we are in this business. One of the things that I think is evident from the speakers, is the fact that we have heard a lot of different citing of this kind of research or that kind of research. My reading of the literature over the years is that a lot of it is piecemeal research. What we really need to do is get this mound of data together and sort it out and find out what really is hard fact in all that data, because there is an awful lot of it that in one methodology will lead you to one kind of a conclusion and in a different methodology and with a different

twist, will lead you in another direction. I am not sure whether anybody knows exactly where we stand.

When you think about the goal of cost containment, it seems to me that what we are really talking about is: How do we separate the efficient from the inefficient hospital? How do we identify efficiency? Because obviously if we have some efficient hospitals, we want them financially stable, so that one of the issues then is to find out how we identify the inefficient hospital and what to do about it.

That raises a corollary question. Are there sufficient cost containment savings to reduce the current cost increases to an acceptable level? I would submit that nobody knows the answer to that one, and we are just fishing in a great big pond. If there are not sufficient savings in cost containment, are there going to be sufficient savings on the demand side, and if it has to go to the demand side, how politically acceptable will that be? The history of Congress and state governments up to now is that it is totally unacceptable politically, so where does that leave us?

The following are some of the myths I've heard in this symposium, along with my reactions to them. *The myth that business leaders will help save hospitals.* My understanding of the situation is that they have been around for a lifetime as trustees, and it seems to me that they have the ultimate authority and they put us in the box we are in. So I don't see any grand new savings by the enlightened business leadership helping the hospital administrator. Furthermore, the thought went through my mind that we are turning out Hospital Administration MBAs with the same core curriculum as the guys running the banks, and how come we are so much more stupid?

The myth that the political clout of the business leader is powerful and can be useful to the hospital. Dave Kinzer is making a lot of mileage today on that speech, which boils down to the issue that they have only so many marbles to spend, and they are going to spend them politically on their business enterprises and not for hospitals. I think the real world is that hospital administrators are going to have to do their own politicking.

The myth that Blue Cross is not an adversary of a hospital. I think that turned into a myth in 1966 when they became fiscal intermediaries, and the corollary to that, as far as I can tell, is that Blue Cross is worried about a national health insurance program and is going to cover its bases. They want to be its fiscal intermediary, and under those conditions I think whatever they say about hospitals is so much hot air.

The myth that we are hearing (it is not a strong myth) that HSAs and PSROs are going to do a job. I think the reality is that they are not going to. They are going to fail, but the problem is that it will never be admitted as a failure, and we are going to live with that myth.

The myth that hospital administrators control hospital costs. Dave talked about that to a degree. Well, I would submit at the margin that hospital administrators only control 10 to 15% and affect the total hospital budget by about that amount.

The myth, not heard in the symposium but believed nationally, that there is a quick fix for cost containment. The reality is that it is a long-time, complex matter.

The myth that rate commissions in states will stabilize hospital financing in the long run. I don't believe that. I think that they are solely and totally a cost-cutting vehicle with a line of sight to the next political election.

What does all of this mean in terms of the way I see the world? I think cost containment can be aimed in three different directions: one is a reduction in the amount and number of clinical services to patients; the second is the substitution of less expensive for more expensive services; and the third is the reduction in units of input for the same units of output. Of those three approaches, the only one that the administrator can do anything about to any degree is the third one—to increase the efficiency of the operation—and what do I see in that?

What I see mostly, with very rare exceptions, is that the data bases hospitals are operating from are grossly inadequate. They are disorganized. They are not articulated. They cannot provide the amount of data needed today to make meaningful decisions in a quick, timely and orderly fashion. If we are going to use that data base adequately, the only thing the administrator can do is look at productivity. What you are looking at there, what really is being said, is that if we effect a voluntary effort of 2% off the present rate of increase, we are talking about a 12.5% reduction in the rate of increase, and if we go to 4% over two years, we are talking about almost 25% cuts in the rate of increase. Unless we are really going to zero in on productivity, we are not going to be able to do it, and we don't have, at the national level, a data base that will guide us on this issue.

So what it all adds up to, I think, is that somehow we have to separate the efficient from the inefficient hospital. The only way I know to do this is to go to

productivity measures and eventually get all hospitals on performance budgeting. If it took us twenty years just to get annual budgeting started in most hospitals, I don't know how long it is going to be before we do performance budgeting, but for the area of cost containment, that is the administrator's responsibility. There is no substitute for going to performance budgeting, and I stop there.

CHAIRMAN ANDERSEN: Lad, do you have any comments you want to make in response to the panel?

MR. GRAPSKI: I don't think so. I would be pleased to answer any questions. I thought as I listened to the panel that there apparently is a good bit of unanimity of opinion as to what was discussed and said, and I would like to hear some good hard questions from the audience.

MR. ERIC JACOBSON: Lad, I heard in what you and Ev were saying and from the comments of a number of speakers, that in the past we have been dealing with a lot of emotional aspects in terms of our planning efforts, and we should now start dealing in realities. I heard you saying that in terms of provision of services. I heard Ev talking about it in terms of provision of services.

"Do the things we can do best. Do the things we can do most efficiently. Do the things we can do most economically" and so forth, and I am wondering: realistically, how far do you think we can go? How do you think we can really get started with this type of activity in light of the more or less emotionally based demands of the public and the pressures on the more or less, realistic situation?

DR. JOHNSON: I think that there is one fundamental in this issue. I don't care if 88% of the people are covered or not. The real issue is that there is pressure on public budgets at the state and the federal level on hospital care, and that is going to get accommodated. I think that is the real world.

Now when you look at the individual hospital in terms of what the administrator can do, you look at its financing, that is a one-time savings. You cut your accounts receivable down, or you do some of the things Lad talked about which are one-time savings. What we have to look for are repetitive savings which have to be on the salary side and staffing patterns of the institution.

Roughly, about two-thirds of the hospital costs are under the control of the administrator. I am talking about labor and non-labor costs in the departments that he can handle. He can touch other things, but really only in a true crisis, so write out energy costs. Write out control of hospital-based physicians' fees. All those kinds of things have to be out for the short run, so we are down to two-thirds of the budget he can do something about, and we have to be able to put pressure on the CEOs in every hospital to do something about it.

That means first of all the administrator has to identify his potential major cost savings areas. I don't think most guys in this country have done that yet. He then has to decide how he is going to go about it step by step in the daily trenches to dig out and try to improve efficiency.

Now what do we always aim for? We aim for medians because that is the way our national data base is set up. Nobody ever says those medians mean efficiency or inefficiency. We don't really know. When you do individual departmental studies you do know that you can beat those medians, but how are we going to turn this whole thing around and do it? It just means we are human beings just as the doctors are, and they will make their mistakes, and we will make ours and we won't be so conscientious. Until we can demonstrate an administrator's unwillingness to cope with costs, we are not going to do anything.

MEMBER: Ev, I would like to dig a little deeper in the area you are talking about, recognizing a hospital is a personal services industry.

I think an area of concern that I have aside from all that we have heard about physician involvement and their accountability for 80% of cost, is recognizing that the paramedical personnel, the nurses and many others in many cases are being motivated, or stimulated, by the physicians. They also have their aspirations and how the administrator can maintain a reasonable level of harmony among the hospital personnel as opposed to tearing the house down and focusing on your third point of productivity performance is getting to be a very sensitive thing. If this level is maintained, of course, it leads to destruction of morale, unionization, and a worsening of the situation.

I think there is a limit to how much the CEO can do in trying to get this increased performance activity from other professionals.

DR. JOHNSON: I am totally aware of that and totally in agreement with you, but I would simply say this. In

the last six or eight months in some work I have been doing, the common pattern that I see in the one and two hospital towns across this country, although this is less true in a place like New York City, is that the board members insist on low wages for the hospital personnel. They don't have ways of providing bonuses and so on, and when you measure their productivity efforts, what you find are low wages and extremely low productivity. Consequently, administrators have to be free to control their wage structures the way they know they ought to be controlled and to get rid of people who are low in productivity and put on some people who will burn the midnight oil for them. I think that is a fundamental problem.

MR. DAVID ENNIS: I would like to add something to that. I am not sure that, using the three points that Ev made, we don't as CEOs have some very important input in the first two points. I think we do. I think we have got to help the boards of our institutions, and in fact, provide leadership for the medical staff in looking at the quality and quantity and scope of services we are providing.

DR. JOHNSON: I didn't mean to leave it at that. I would totally agree with what you have said.

MR. ENNIS: That is the first time in a long time.

DR. JOHNSON: I would like to move that we limit this meeting to Chicago graduates.

I would agree that we have to provide the leadership. I am just saying that the internal area is the one thing the administrator can work on unobstructed from the other constraints of the larger issues.

MR. ENNIS: We are getting close.

MR. ALEXANDER HARMON: I would like to make a brief observation, and I don't want to expand on it or I will get in trouble, but we talk about Catch-22. I think we have got to come up with another term. That just isn't big enough for the bind we are in.

It seems to me that we are concentrating so much on hospitals reducing and containing costs that we are overlooking the cost containment needed within the ranks of the medical profession itself.

What doctors can do for patients in consideration of the availability of the technology that now enables them to practice the high quality of medicine that they can now practice, is at odds with the goals required of hospital administrators. From current data released on incomes, I can only conclude that doctors are having a far more successful time in collecting for these

increased and improved services than the hospitals are. Recognizing the significant input that they have into the whole matter of hospital costs, is really something greater than Catch-22. In truth, I don't know what that answer is.

All I know is that in our shop we constantly have the problem of how we are going to finance not less but more and more and more, and now the CAT scanner is no good unless it has a computer attached to it—a modest \$100,000 more. And that is just one example, so that really our dependence on the profession and technology and science and all the rest has somehow or other got to get into this movement if it is to succeed, or as Ev said, we just add this to another long line of myths.

CHAIRMAN ANDERSEN: One final comment.

MR. JOHN C. IMHOFF: I would like to add that as we increase our concern about improving our marketing capability, we find ourselves in another Catch-22. We find our doctors saying, "If you do this for me and that for me, I will come to your shop and work for you." Improve your services and spend more money and then you will be a more successful hospital, so that is another Catch-22.

**PANEL DISCUSSION WITH RUSSE, EVERHART,
JOHNSON, GRAPSKI**

CHAIRMAN ANDERSEN: Odin wanted to make a few concluding remarks, and he seems to be the appropriate person to respond to issues of Catch-22.

DR. ODIN W. ANDERSON: I opened the meeting and I guess it is appropriate for me to close the meeting with very brief remarks. I wish to thank everybody here who came to listen and to ask questions and everybody who came to deliver papers in good humor, and I wish to end with a story.

Ron started with a story this morning, a naughty but innocent story, so I have to match him with the naughtiness in my story which I think is within the framework of the conference and the framework of supply and demand.

The scene is an obstetrical unit and the birth had just taken place. The father was present. It was a very progressive hospital.

It had been a somewhat difficult birth. The episiotomy had been performed and the obstetrician was sewing up the mother.

He turned to the father and said, "Say when."

List of Participants

Lu Ann Aday
Center for Health Administration Studies
University of Chicago
5720 S. Woodlawn Ave.
Chicago, IL 60637

David L. Allen
Health Care Fin. Admin., D HEW
175 W. Jackson Blvd.
Chicago, IL 60604

Ronald Andersen
Center for Health Administration Studies
University of Chicago
5720 S. Woodlawn Ave.
Chicago, IL 60637

Odin W. Anderson
Center for Health Administration Studies
University of Chicago
5720 S. Woodlawn Ave.
Chicago, IL 60637

Harold L. Autrey
Perry Memorial Hospital
530 Park Avenue E.
Princeton, IL 61356

Mark P. Bader
Jackson Park Hospital
7531 S. Stony Island
Chicago, IL 60649

Richard O. Baer
The Ohio State University
232 Medical Administration Center
370 W. 9th Avenue
Columbus, OH 43054

Barry T. Bedenkop
Mile Square Health Center
2045 W. Washington Blvd.
Chicago, IL 60612

Penn Berens
Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, OH 44116

Weston D. Bergman, Jr.
Grady Memorial Hospital
80 Butler St., S.E.
Atlanta, GA 30303

James I. Boyce
O'Bleness Memorial Hospital
Hospital Drive
Athens, OH 45701

George Bugbee
University of Chicago
Genesee Depot, WI 53127

Michael Burack
Multi-Risk Mgt., Inc.
180 North La Salle
Chicago, IL 60601

Roland R. Carlson
The Youngstown Hospital Assoc.
South Unit
345 Oak Hill Avenue
Youngstown, OH 44502

Les Cattrall
Mem. Hosp. Med. Center of Long Beach
2801 Atlantic Avenue
Long Beach, CA 90801

W. Christopher Clark
Northside Hospital
1000 Johnson Ferry Rd., N.E.
Atlanta, GA 30342

Sr. Mary Croghan, O.S.F.
St. Joseph's Hospital
3001 W. Buffalo Avenue
Tampa, FL 33607

Charles H. Dawe
Schmidt, Garden & Erikson
104 S. Michigan Ave.
Chicago, IL 60603

Brendan F. Egan
Henrotin Hospital
111 West Oak Street
Chicago, IL 60610

Robert Emerman
Robert B. Brigham Hospital
125 Parker Hill Avenue
Boston, MA 02120

David W. Ennis
Mid. Ohio Health Planning Federation
P.O. Box 2239
Columbus, OH 43216

Wm. H. Ennis
Hamot Medical Center
201 State Street
Erie, PA 16512

R. D. Erickson
ServiceMaster Ind., Inc.
Hospital Central Division
2300 Warrenville Road
Downers Grove, IL 60515

E. T. Evans
St. Luke's Hospital
915 East First Street
Duluth, MN 55805

Shoshana Falk
Governors State University
Park Forest South, IL 60466

J. Daniel Ford
Witt and Dolan Assoc.
1415 West 22nd Street
Oak Brook, IL 60521

David Fosse
South Chicago Community Hospital
2320 E. 93rd Street
Chicago, IL 60617

Richard W. Foster
Grad. Prog. in Hospital Adm.,
University of Chicago
5720 S. Woodlawn Ave.
Chicago, IL 60637

Lewis Freiberg, Jr.
Blue Cross/Blue Shield Assoc.
211 East Chicago Avenue
Chicago, IL 60611

Evan Freund
Michael Reese Hospital & Medical Center
29th Street & Ellis Avenue
Chicago, IL 60616

Samuel A. Friede
Michael Reese Hospital & Medical Center
29th Street & Ellis Avenue
Chicago, IL 60616

P. Timothy Garton
Grad. Prog. in Hospital Adm.
5720 S. Woodlawn
Chicago, IL 60637

Dean E. Grant
Alexian Brothers Medical Center
800 W. Biesterfield Road
Elk Grove Village, IL 60007

Lad F. Grapski
Allegheny General Hospital
320 East North Avenue
Pittsburgh, PA 15212

Howard Greenwald
University of Chicago
5409 S. Blackstone
Chicago, IL 60615

Phillip J. Haas
North Suburban Assn. for Health Res.
1255 N. Milwaukee Avenue
Glenview, IL 60025

Robert C. Hardy
Oklahoma Health Sciences Found.
324 N. Robinson—Suite 216
Oklahoma City, OK 73102

Alexander Harmon
The Christ Hospital
2139 Auburn Avenue
Cincinnati, OH 45219

Bernard Harris
Evanston Hospital
2650 N. Ridge
Evanston, IL 60201

David M. Hatfield
United Hospitals Incorporated
300 Pleasant Avenue
St. Paul, MN 55102

Dan Hauser
ServiceMaster Ind., Inc.
Hospt. Cent. Div.
2300 Warrenville Road
Downers Grove, IL 60515

Paul A. Hofstad
Fairview Community Hospitals
2312 S. 6th Street
Minneapolis, MN 55454

James E. Hosking
Herman Smith Associates
120 E. Ogden Avenue
Hinsdale, IL 60521

G. Edwin Howe
St. Luke's Hospital
2900 W. Oklahoma Avenue
Milwaukee, WI 53215

Kenneth W. Huckendubler
Bronson Methodist Hospital
252 E. Lovell Street
Kalamazoo, MI 49007

John C. Imhoff
The Mountainside Hospital
Bay & Highland Avenues
Montclair, NJ 07042

Eric P. Jacobson
St. Bernard Hospital
326 W. 64th Street
Chicago, IL 60621

Gary E. Kaatz
Rush-Presbyterian-St. Luke's Med. Center
1753 West Congress Pkwy.
Chicago, IL 60612

Robert P. Katzfey
Proctor Community Hospital
5409 North Knoxville Avenue
Peoria, IL 61614

Carol Kehoe
Cincinnati General Hospital
234 Goodman Street
Cincinnati, OH

Philip H. Kell
Gratiot Community Hospital
300 S. Warwick Drive
Alma, MI 48801

David H. Klein
Blue Cross/Blue Shield Assoc.
840 North Lake Shore Drive
Chicago, IL 60611

Larry L. Kron
Galesburg Cottage Hospital
695 N. Kellogg Street
Galesburg, IL 61401

David Kruegel, Ph.D.
Veterans Administration
Health Services Res. & Dev.
Washington, DC 20420

Elizabeth J. Kurtz
St. Luke's Hospital Center
113th St. & Amsterdam Avenue
New York, NY 10025

Alfred R. Kurtz
Alfred R. Kurtz & Associates
12 Beekman Place
New York, NY 10022

Louise L. Kurylo
Blue Cross/Blue Shield Assoc.
840 North Lake Shore Drive
Chicago, IL 60611

Everett A. Johnson
The Dunes Group
Suite 496—Marquette Mall
Michigan City, IN 46360

Arthur Leyland, Jr.
Blue Cross/Blue Shield Assoc.
840 N. Lake Shore Drive
Chicago, IL 60611

George A. Lindsley, M.P.H.
Illinois Department of Public Health
5th Floor, 525 West Jefferson
Springfield, IL 62761

Marshal G. Maggard
Galesburg Cottage Hospital
695 N. Kellogg Street
Galesburg, IL 61401

Edward J. Mally
Loyola University Medical Center
2160 South First Avenue
Maywood, IL 60153

John R. Mannix
1021 Euclid Avenue
Cleveland, OH 44115

Ronald M. Mattei
St. Joseph Mercy Hospital/
Sisters of Mercy Health Corp.
900 Woodward Avenue
Pontiac, MI 48053

Richard Maturi
Blue Cross/Blue Shield Assoc.
840 N. Lake Shore Drive
Chicago, IL 60611

J. Joel May
Health Research and Educational Trust
760 Alexander Road CN-1
Princeton, NJ 08540

David McNary
Northwestern Memorial Hospital
303 East Superior Street—Rm. 245
Chicago, IL 60611

Joseph Morris
NJ State Department of Health
John Fitch Plaza
Trenton, NJ 08625

Robert G. Ostrowski
University of Illinois Hospital
840 South Wood Street
Chicago, IL 60612

Edwin W. Parkhurst, Jr.
Herman Smith Associates
120 East Ogden Avenue
Hinsdale, IL 60521

Bradford G. Perry
Nat'l. Ctr. for Health Services Res.
3700 East-West Highway
Hyattsville, MD 20870

Richard Polheber
Tucson Medical Center
P.O. Box 42195
Tucson, AZ 85733

Jack Pollock
ServiceMaster Industries, Inc.,
Hosp.-West Central Division
1000 Executive Parkway
St. Louis, MO 63141

Leon C. Pullen
Herman Smith Associates
120 E. Ogden Avenue
Hinsdale, IL 60521

Theodore Raichel
Blue Cross Association
840 N. Lake Shore Drive
Chicago, IL 60611

Ronald W. Ree
Illinois Masonic Medical Center
836 Wellington Avenue
Chicago, IL 60657

Leah Resnick
Bur. Health Planng. & Resource Dev.
Div. of Facilities Dev., Hyattsville, MD
2939 Van Ness St. N.W.
Washington, DC 20008

Douglas O. Rosenberg
Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201

Anthony J. J. Rourke, Jr., M.D.
Anthony J. J. Rourke, Inc.
550 Mamaroneck Avenue
Harrison, NY 10528

Francisco D. Sabichi
Penrose Community Hospital
3205 North Academy Boulevard
Colorado Springs, CO

Peter Sammond
Mount Sinai Hospital
2215 Park Avenue
Minneapolis, MN 55404

James A. Schindler
Deaconess Hospital of Buffalo, NY
1001 Humboldt Parkway
Buffalo, NY 14208

Donald G. Shropshire
Tucson Medical Center
Box 42195
Tucson, AZ 85733

John A. Smith
Proctor Community Hospital
5409 N. Knoxville Ave.
Peoria, IL 61614

Peter J. Snow
Herman Smith Associates
120 E. Ogden Avenue
Hinsdale, IL 60521

Ronald G. Spaeth
Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201

John M. Stagl
McGaw Medical Center
339 E. Chicago Ave., Room 119
Chicago, IL 60611

W. Vickery Stoughton
Affiliated Hospitals Center
721 Huntington Ave.
Boston, MA 02115

Frank C. Sutton, M.D.
300 E. Schantz Avenue
Dayton, OH 45409

David H. Tower
Johns Hopkins University &
Johns Hopkins Hospital
601 N. Wolfe Street
Baltimore, MD 21205

Edgar W. Tuttle
University Hospital, Inc.
75 E. Newton Street
Boston, MA 02118

Gail L. Warden
American Hospital Association
840 N. Lake Shore Drive
Chicago, IL 60611

Norman Webb
South Chicago Community Hospital
2320 E. 93rd St.
Chicago, IL 60617

Russel B. Williams
Kaiser Foundation Hospitals
4747 Sunset Boulevard
Los Angeles, CA 90027

Sherman R. Williams
Nat'l. Ctr. for Health Serv. Research
3700 East-West Highway
Hyattsville, MD 20782

Irvin G. Wilmot
New York University Medical Center
550 First Avenue
New York, NY 10016