

**Managing for Growth
and Future Expansion**

*Proceedings of the Twenty-second Annual
George Bugbee Symposium on Hospital Affairs, May 1980*

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

The Twenty-second Annual George Bugbee 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 May 28-30, 1980. 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 Twenty-second 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 staffed the symposium, and to Ms. Roberta Arnold who edited these proceedings.

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Introductory Remarks

RONALD M. ANDERSEN, CHAIRMAN

The Twenty-second Annual George Bugbee Symposium on Hospital Affairs convened at 9:00 A.M. Thursday, May 28, 1980, in the Assembly Room of the Center for Continuing Education at the University of Chicago, with Ronald Andersen, professor of the Graduate School of Business, University of Chicago, presiding as chairman.

I would like to welcome you to the Twenty-second Annual George Bugbee Symposium on Hospital Affairs, sponsored by the Graduate Program in Hospital Administration and the Center for Health Administration Studies of the Graduate School of Business of the University of Chicago. The symposium's program is developed jointly by the Council of the Alumni Association, headed this year by Dick Johnson, and the faculty of the program, headed by Odin Anderson, director of the Graduate Program in Hospital Administration and the Center for Health Administration Studies.

It is a special pleasure to call this session to order. As many of you know, at a recent Alumni Association meeting our symposium was named in honor of George

Bugbee. He served as director of the graduate program from 1962 to 1970, following an outstanding career as a hospital administrator and executive director of the American Hospital Association. George has continued to be a mainstay of our program; I would like to mention in particular his continual involvement in our hospital survey for the second-year students in the hospital administration program.

As Joel May pointed out while making the award to George, it seems most appropriate that our symposium should be named in his honor because he has had so much to do with its development, following its initiation by Ray Brown in 1958. George's educational philosophy embodies what we have striven for in the symposium over the years. First, we have attempted to explore the significant issues in the management of health services delivery. In addition, to better understand these issues, we have made efforts to combine the experiences of practitioners in the health services with the findings of health services research. Finally, in dealing with the problems of our field we have tried to maintain both a healthy pragmatism, given our current knowledge, and a willingness, in fact a desire, to alter positions as we learn more and as the needs of the field change.

The Health Services as a Continuous Growth Enterprise

ODIN W. ANDERSON

CHAIRMAN ANDERSEN: Our leadoff speaker is Odin Anderson, and even if he were not responsible for developing the program, I think he would still be a very appropriate leadoff speaker. I'm not going to go into Odin's qualifications; if you are not impressed by them by now, there is nothing I can say that will change that. However, I would like to share with you one of his recent honors.

Two years ago the Medical Sociology Section of the American Sociological Association inaugurated a distinguished medical sociologist award, an award given to a person whose career has contributed significantly to the development of medical sociology and health services research. Odin will receive this award at the August 1980 meeting of the American Sociological Association.

Our title today, "Managing for Growth and Future Expansion," is a rather optimistic one, and Odin will let us know if, in his view, this optimistic title is warranted.

ODIN W. ANDERSON: Thank you very much. Although I was the program chairman, there seemed to be a consensus in the committee with which I was working that I should lead off, and so I humbly followed the mandate. I was drafted—but not too reluctantly.

I want to give you some idea of the tremendous momentum that has existed in the health field for a long time, a momentum which has its own generating power. Thus I have titled my discussion, "The Health Services as a Continuous Growth Enterprise." Although Ron called that optimistic, the health services in the United States have actually been a growth enterprise for at least 100 years. As one reviews this growth in the context of the expansion of the economy and medical technology, one senses a tremendous momentum welcomed by the country as a sign of progress toward the alleviation and cure of the many ills of humankind.

The health services takeoff period started in 1950 as they absorbed the burgeoning chemotherapeutic and technological developments made up to that time. The

acceleration of health services' use and prices became visible in the later sixties and early seventies.

It is only during the last five years that this momentum has begun to be questioned, but so far no really *serious* attempt has been made to curb it. During the past five years one set of controls after another has been instituted with, as yet, no results in terms of slowing this momentum. We seem to be facing a situation of continuous expansion well into the future. Let me give you my impressions about why this is so by indulging in a brief history of the American health services' stages of development.

The development of the health services in America as well as in other industrialized countries may be divided into three periods. For the United States, the first period extended from 1875 to 1930; the second, from 1930 to 1965; and the third, from 1965 to the present.

I

Briefly put, the period from 1875 to 1930 was one in which the personal health services infrastructure was put in place. By the twenties the American health services delivery systems assumed the basic characteristics we know today: voluntary hospitals, supplemented by public hospitals; private practicing physicians, who rapidly made arrangements with the voluntary hospitals for the admissions of their patients but who also maintained office practices; dentists with independent office practices and a few dental surgeons with hospital arrangements; nurses, who became largely hospital based; and the pharmacists, who continued their long-established independent drug stores. This health care delivery system was essentially privately supported. Voluntary hospitals had been capitalized by philanthropists and were products of the tremendous industrial expansion of the late nineteenth century which resulted, in the minds of such philanthropists, in an economic surplus available for "good works." Voluntary hospitals also depended on community fund drives for capital. In the early twenties it was estimated that roughly two-thirds of the daily expenditures of hospitals came from private patients; the rest came from philanthropy and state and local governments.

By 1920 or so the parallel public health departments, the U.S. Public Health Service and the state and local health departments, were in place to control communicable diseases and to assure a salubrious environment. Mental hospitals funded by the states and, to some extent, the counties were established a little earlier to take the mentally ill off the streets and from their families. When communicable diseases were no longer the leading causes of death, it seems that the exciting developments, from the standpoints of the public, the hospitals, and physicians, were in the acute and curative sectors of the total health services.

The surgeon-entrepreneurs made the first arrangements with the hospitals for admission privileges, but by 1914 physicians in general medicine did the same in increasing numbers, and by the thirties more and more obstetricians were hospitalizing their maternity patients. The physicians and dentists were, and are, essentially privately practicing entrepreneurs responsible for their own capital funding of their offices, and they earned their living from fees. No industrialized country was able—or perhaps willing—to support a personal health service from private philanthropy, community fund raising, and fees. The very conception was lacking. Care for the poor was a residual of the system. The American health services became essentially private because this country had a broad-based mass purchasing power unequalled by any other country at the time. I believe that this particular heritage harbored an entrepreneurial characteristic and an emphasis on convenience of access and amenities which reflected the flourishing economy and a concept of limited government. Government ownership and regulation were nonissues.

A few statistics illustrate the rapid growth to which I have been referring. In 1875, when the U.S. population was about 50 million, there were 178 hospitals, probably around 71,000 beds or 1.42 beds per 1,000 people, and an admission rate of less than four per 1,000. Physicians were in good supply, largely because of the state of the art. Nurses were few because of few hospitals. Pharmacists did not have an easy time of it because the physicians usually dispensed their own medicine; consequently, the corner drugstores added ice cream parlors and carbonated beverages. Other supporting personnel, such as laboratory technicians and dietitians, were virtually nonexistent.

All this changed with the advent of anesthesia, which made surgery painless, and antisepsis, which made the

hospital environment less conducive to postoperative infections. By 1910, thirty-five years later, there were 4,400 hospitals and over 420,000 beds or 4.7 beds per 1,000. The number of physicians, relative to the number of people, remained quite constant, but the number of nurses increased dramatically. Hospital directors began to ride a cost escalator. The complaints of hospital administrators of those days are similar to the complaints of their counterparts today; in fact, the addresses to the annual meetings of the American Hospital Association at that time, around 1900 to 1910 or 1914, feature problems familiar to the hospital administrators of today: physicians clamoring for new and expensive technology, such as equipment for roentgenology and sparkling operating theaters; the need to improve the system and maintain standards while at the same time holding down costs; and so forth.

Nevertheless, the health services prospered, as measured by growth in relation to population increase. By 1920, there were over 6,000 hospitals and 800,000 beds, or 7.7 beds per 1,000. Services increased greatly, and there was about the same proportion of doctors to people. In 1923 it was estimated that the admission rate to hospitals was thirty-eight per 1,000, with an average length of stay of thirteen days.

It should be noted that there were in essence no third-party payers except for the reluctant philanthropists and governments who funded care for the poor at reduced rates. From 1900 there were sporadic comments regarding the burden of costs for increasingly expensive episodes: "The rich and the poor get care, but the broad middle class must suffer," went the refrain. An expression of this was the abortive attempts in sixteen states from 1916 to 1918 to exact compulsory health insurance legislation. Voluntary health insurance, as we know it today, was nonexistent.

II

I describe the period from 1930 to 1965 as the era of the emergence of the third party. There was anecdotal information that self-supporting families were having difficulty paying for unexpected hospital and medical bills. The number of families with such difficulties was increasing because of the changing nature of medical practice and technology. From 1928 to 1931, the studies by the Committee on the Costs of Medical Care, funded by six foundations, established for all time the uneven

nature of health services expenditures for families in a year. The insurance concept was born and with it an engine of rather easy money for the health services enterprise. For forty years—say, 1935–75—the hospitals and physicians were paid virtually what they charged. The atmosphere was a free and easy one, as was true of the entire economy after World War II started for the United States in December 1941. Added to that was a government decision which encouraged employer participation in paying for the health insurance premiums of its covered employees, premiums which were tax deductible as a business expense and were not regarded as part of wages. Furthermore, this was a nontaxable subsidy for the employees. The money pot in the expanding U.S. economy was seemingly inexhaustible, and no one—the employee, the employer, the government, or the taxpayer—could determine what his individual and personal cost or cut might be. By 1965, about 75 percent of the population had some form of voluntary health insurance.

In that year Medicare and Medicaid were established by an act of Congress after a protracted and intensive political debate which allowed another 20 million people, or 13 percent of the population, relatively unrestricted access, at least as far as payment was concerned, to the personal health services enterprise. Cost controls were not considered, at least not seriously, during this second period; the prevailing policy was, pay hospitals costs or charges, whatever is lower, and to physicians, pay the customary and reasonable fees, with no negotiated fee schedules. The only concern was fraud. There were no incentives for cost containment because the economic and political climates were not conducive to cost containment as an end in itself. Increased access and equality of access across family income levels were the primary objectives.

Thus, by the end of the sixties and beginning of the seventies we saw the health services economy begin to take a leap in expenditures relative to the rest of the economy. When overall expenditures in health services began to increase 10 percent per year and hospital costs increased 15 percent, politicians, civil servants, industry, and labor unions, the big *buyers* of services, began to be concerned, but the users of health services were not. Users wanted more and better insurance coverage.

It is apparent from the foregoing that after 1965 we entered another and third stage in the development of the health services enterprise in the United States. This stage became inevitable as health services allocations

began to compete with other allocations by government and industry, the primary buyers of services. So far, at least, insurance agencies are not *buyers* of services; they are mainly payment agencies. But they were also becoming concerned.

Until the thirties, no one knew what total health services expenditures were. But in 1929 the Department of Commerce began assembling national expenditure and use data for the health services and their components. At that time also, the concept of and method of measuring the GNP were developed, so health services expenditures could be compared with the GNP. Thus we now have available to us a detailed history of the trends in health services use and costs.

The use of hospitals increased from ninety admissions per 1,000 population in the thirties to 150 twenty years later. The proportion of the population seeing physicians at least once a year increased from 40 percent to 65–75 percent during the same period. There was a greater equalization of access to, and consequently greater use of, health services among various income groups. Access to maternity services by first pregnancy trimester expanded and equalized across income classes. The increases in the supply of hospital beds and physicians and the tremendous financing engines from government and voluntary health insurance were ingredients for an expenditure take off which became evident shortly after the establishment of the Medicare and Medicaid programs.

III

The third period is marked by the emergence of intrusive management and general controls on the system. I think that in previous years, management was mainly facilitative in an environment with few financial constraints. In the future, management will be directly interventionist, allocating resources in an environment characterized by pervasive planning (PL94-641) and controls on use and supply.

For this audience I hardly need to describe in any detail the control systems that are more or less in place within which managers are supposed to bargain, plead, and fight for their hospitals and medical consortia. The criteria are understandably unclear because criteria of supply and use, and consequently overall expenditures, have no reference point in an input-output sense. Hence, the levels of supply, use, and expenditures have become completely politicized. The equilibrium to be reached among supply, demand, and expenditures is

now pretty much in the political bargaining market rather than in the largely private nongovernmental market which existed before the Planning Act, Professional Standards Review Organizations (PSROs) certificate of need (CON), and rate-review regulatory methods. The Planning Act is designed mainly for consumer influence on the determination of need in local areas with a scarcity of providers. Since the health service agencies are planning agencies only and have no money to buy services, I believe their tendency is toward expansion, federal criteria notwithstanding. There are now over 200 health services planning areas in the fifty states.

Let us take an overall systems approach to the American health services to determine the sources and destinations of expenditures and the choice of controls on supply, price, and use of services. The description of the current possibilities for controls will probably be the same for some time, with the possible exception of increased government funding in the event of some form of national health insurance and its implication for increasing government leverage on financing and reimbursement methods.

Currently the medical dollar is divided among service components as follows: hospital, 40 percent; physician, 20 percent; drugs and sundries, 8 percent; dental, 6 percent; nursing homes, 8 percent; and all other, 16 percent (total for United States for one year: \$200 billion.). It is estimated that annual expenditures now average about \$800 per capita. Because hospitals account for the largest portion of expenditures (40 percent of the medical dollar), hospitals get the most attention when it comes to the curbing supply, use, and price. However, doctors (and patients) also deserve scrutiny but rarely receive it because of fear of directly confronting the physicians. Thus the hospital manager has control of possibly only one-half the expenditures, the so-called hotel expenditures. The physician is the primary decision maker, determining the expenditure of around 80 percent of the total health dollar (or roughly \$300,000 per practicing physician); attempts are made to rationalize the physician's position through the PSRO mechanism.

Currently, around 40 percent of all expenditures come from government sources and 60 percent come from private sources—insurance and out-of-pocket payments. Thus government, in its contracting and reimbursement methods, has the potential to influence 40 percent of all expenditures. However, let us look at a more detailed breakdown of the payment sources for

the entire system in order to get a rough idea of the *potential* leverages on expenditures. The current distribution is 40 percent government (28 percent federal and 12 percent state and local), 28 percent voluntary health insurance, and 30 percent out-of-pocket payments. (This leaves 2 percent from philanthropy.) The federal leverage is mainly through Medicare, a completely federal responsibility. The federal government contributes a little over one-half of the expenditures for Medicaid; the state and local governments provide the rest.

Because over one-half of the hospital income is from public funds for Medicare and Medicaid, the greatest potential government influence is on the hospitals. On the average, only 24 percent of a physician's income is from government sources, mainly, I assume, for inpatient services. While 6 percent of the hospital income is from out-of-pocket sources, that source provides 39 percent of a physician's income. To some undetermined extent, there are controls on the consumer through deductibles and co-insurance.

Can expenditures be contained by the system I have described? Is it still "riotous pluralism," as an Englishman called our health services some years ago, or are we moving toward a more structured pluralism within which the rules for initiative and control are spelled out and the adversaries—the public, providers, insurance agencies, and government—can square off and evolve a variation of patterns of health services and delivery methods more or less congruent with local conditions? This method, I believe, is inherently expensive, but unless there is a looseness (wastefulness?) in the system, any reduction of supply of services that produces queues and limited choices will result in many Americans opting for a flourishing private system.

Will the health services continue to expand? My guess is, yes, but not in the same way as they have during the last thirty years. The health field will continue to be inherently expansive, for reasons I will describe in due course. Managerial staff will assume more importance than it has previously held so that this expansion can be directed with much better knowledge of demand and need in the service areas, with more sophisticated skills for dealing with essentially political issues and forces, and with much greater skill in dealing with the medical profession. For its part, the medical profession will need to develop much greater skill in dealing with manage-

ment on behalf of the patient. The manager is advocate for and custodian of community resources; the physician is the advocate for and custodian of the individual patient. The inherently adversary relationship between physicians and health services managers will need to be more structured and codified than it has been up to now. The manager and the physician will have to learn how to contend with the increasingly corporate characteristics of the health services industry while they try to preserve the humane characteristics of the essentially one-to-one relationships of a personal service. They will have to construct an administration peculiar to the personal health services and not be overdependent on the industrial and business models, for the health services deal with sick people to whom money is of no concern, while industry and business deal with healthy people who presumably make rational, cost-effective decisions as they buy and sell commodities and services.

To show what an accurate prophet I am: In 1967 I was invited by the American Institute of Planners to contribute a position paper on the state of the health field for the next fifty years; I was to forecast expenditures based on trends already present. I predicted that by 1980 this country would be spending 9 percent of its GNP for health services. We are there. Members of the panel which discussed my paper were distressed with my predictions and challenged their validity, given my assumption that Americans would want to continue to spend a relatively large sum of money for health services. However, at the same time I predicted that the expenditures would stabilize at 9 percent; now I wish to revise my estimate upward: It will be 12 percent by—or before—1988.

In this I am helped considerably by recent estimates by the staff of the Health Care Financing Administration (HCFA),¹ an agency which I would assume would prefer to be conservative in its estimates so as not to frighten Congress unduly. Still, on the basis of the following assumptions, they predict continuing expansion:

1. Per capita use of medical care will continue to grow in accordance with historical relationships and trends.
2. No mandatory cost containment program will be in effect.
3. No major new publicly financed program of medical

¹Mark Freeland, George Calat, and Carol Ellen Schindler, "Projections of National Health Expenditures, 1980, 1985, and 1990," *Health Care Financing Review* 1 (Winter 1980): 1-27.

care, such as national health insurance, will be in effect.

4. There will be no major technological breakthrough in treatment of acute and chronic illnesses which would significantly alter patterns of morbidity and mortality.
5. Medical care prices will vary with a consumer price index for all items, according to relationships established in the historical period.
6. Health manpower will increase in accordance with the projections made by the Bureau of Health Manpower.
7. Population will grow in accordance with projections of the Office of the Actuary, Social Security Administration.
8. The CPI and the GNP will grow in accordance with the Office of Management and Budget projections through 1985. Annual percent age changes for 1986 to 1990 are assumed equal to the 1984 to 1985 percent age changes.
9. Benefit outlays for Medicare and Medicaid through 1985 will grow in accordance with projections made by the Divisions of Medicare and Medicaid Cost Estimates in the HCFA Projections for 1986 to 1990.²

Freeland, Calat, and Schindler assume only one scenario—the continuation of current trends and relationships. They note that projections could also be made for alternative scenarios, such as national health insurance or cost containment versus the emergence of significant price competitions in the health care industry. The authors feel that "in the absence of evidence to the contrary, the most reasonable assumption . . . is that current trends and relationships will continue into the future."³

For 1980, the estimated total expenditures are \$245 billion (compared with \$75 billion in 1970) and per capita expenditures, \$1,078 (compared with \$395 in 1970). It is estimated that in 1990, expenditures in the health services will amount to 11.5 percent of the GNP (compared with 7.6 percent in 1970). Last year, after having been in Sweden, I predicted privately that the expenditures would go up to 12 percent of the GNP within ten years. Here are my reasons:

As I said, the controls or regulatory mechanisms for

²Ibid.

³Ibid.

the health services delivery system—the Planning Act, PSROs, CON, and rate review—are *in place*. Thus we have a regulated health services delivery system which has the potential to evolve into a public utility, that is, a monopoly as a sole supplier of health services and goods, analogous to the telephone, gas, and electricity companies. It is an easy way to go, and the health services in many other countries are developing in this way. However, a countertrend to monopoly—one which is being discussed and debated more and more these days—is competition, structuring the pluralism of the current delivery options. The health maintenance organization (HMO) is regarded as the spearhead of this concept and is receiving renewed support from government funds for that purpose. This is the only country which has the setting and the potential to try out *competition*, rather than the regulatory and the public utility models, as a means of increasing efficiency and containing costs. Even so there has to be a certain amount and type of regulation to establish a framework for fair competition.

I believe that there are fundamental forces and desires which will push toward expansion of the health services regardless of the delivery models—monopolistic or competitive, regulated or unregulated—that may predominate. Even in a competitive model the costs will have no particular reference to what a scientifically established cost might be. Although one model may deliver a range of services at a lower cost than another model, the lower cost may still be regarded as excessive. Consumer sovereignty will not be allowed to hold sway, particularly if there is enacted a fairly comprehensive form of compulsory national health insurance as a result of which health services will be competing directly with a range of government programs and priorities.

Here are the factors, given in order of their estimated impact, that will tend to increase the demand and expenditures for personal health services in the future.

1. *The quality imperative*: This is a term borrowed from Robert Havighurst, by which he means that the medical profession and the hospital administrators will threaten to lower quality of services (aside from amenities) if appreciable retrenchments are mandated. The physicians are in control of quality determinations in their professional judgments. The PSROs are run by physicians according to implicit rather than explicit group norms; such norms can be lowered or raised by professional consensus.

2. *The technological imperative*: All evidence points

to increased and expensive medical technology which requires additional operating staff. Proper distribution of this technology in order to prevent duplication will not reduce the increased expenditures but will simply slow the pace of increase. Sophisticated surgery (e.g., microsurgery) will increase, as will the portion of the population which will not ask for arterial bypass surgery, dialysis, and a host of other procedures and technologies (including those yet to be developed).

3. *The aging population*: As more and more people live longer, we have to contend with more and more illnesses, especially chronic diseases and ills accompanying old age.

4. *Equalization of access to services*: This has improved, as I indicated earlier, but there is still a lot to be done in terms of access by severity of medical condition and residence. It does not seem reasonable to assume that access will be limited for upper-income groups as it is expanded for lower-income groups; rather, the trend is to increase the access for those at the bottom without decreasing it for those at the top.

5. *Primary and preventive care and treating the whole person*: The increasing emphasis on primary and preventive care and on treating the physical and psychological aspects of a person will tend to increase the use of our health services.

6. *Physician supply*: The physician supply is increasing, and, to paraphrase Roemer's Law, a physician present will be a physician sought—and bought. We are not quite sure what the saturation point for physician services may be.

7. *Compliance with physicians' orders*: Studies on patient compliance with physicians' orders, especially routines for prescribed drugs, reveal that a great number of patients do not follow orders. The assumption is made that patients should be good patients, they should comply. Increased compliance will probably result in increased expenditures.

8. *Dental services*: By all standards, dental services are notoriously underused. Increased use of dental services to maintain mouths full of teeth, natural or artificial, will increase costs.

9. *The convenient- and fast-service imperative*: Perhaps another factor which will increase health services' use and expenditures is the peculiarly American characteristic which I call the convenient- and fast-service imperative. Less waiting and more convenient

access—not to mention more amenities—have been expected much more in this country than elsewhere. This expectation will continue, and if we have a comprehensive national health insurance plan with its inevitably inadequate financing and queuing, there will be an expansion of an affluent private sector which will assure a high expenditure level from private and even public funding sources.

10. The *hospice movement*: A final factor in my list, and in reality as well, is the emerging hospice movement. This has resulted in the development of special accommodations and specialties for those who are dying, usually as a result of cancer. Presumably these patients will be removed from expensive acute hospitals, but here we may have at best a cost exchange rather than a cost cut. A new specialty would seem to add new expenditures.

After this somewhat overwhelming list of factors increasing the demand for and costs of health services, can we locate any countertrends which may help to reduce expenditures for health services by reducing demand?

1. *Improved life-styles*: A popular trend today is the allegedly healthier life-style characterized by more exercise, proper diet, and general moderation in habits. There is evidence that mortality from heart attacks has begun to drop, but this probably leaves more survivors with chronic conditions. It is not known whether the run-for-your-life movement, part of this life-style change, will result in decreased health services expenditures. I understand, however, that orthopedists are getting much more business.

To continue with life-styles: Smoking, alcoholism, and drug addiction still appear to be inherent in the human condition, unless there would be a religious movement which would change behavior. Judging by the patterns of causes of death among Mormons, it apparently would help if we became converts to that religious denomination.

2. *Medical self-help*: The concept of self-help is getting increased attention; it does not literally mean “help yourself,” but one aspect of it involves learning more about one’s own body and symptoms and practicing some self-treatment, including self-medication. For years I have been wondering about the usefulness of a Doctor Spock for adults. It seems that respiratory symptoms from the neck up, which are generally self-limiting, do not need a physician’s attention but, rather, require forbearance and endurance by the patient. Respiratory symptoms from the neck up account for 15 percent of the visits to the physician. A reduction in such visits could produce appreciable savings. However, human beings are able to invent or discover new ailments for professional attention as other ailments are reduced or eliminated.

If the health services delivery system is to respond to apparent demand, the expenditures must go up. If it is not to respond to demand, the result will be a decrease in the supply of services and queuing. In a largely publicly funded system it is possible to reduce expenditures provided there is a docile public, but in this country a large minority will opt for an affluent private sector. Nevertheless, skillful management will be necessary to justify health services costs, if not to reduce them.

Fork in the Road: Competition and Regulation

RICHARD W. FOSTER

CHAIRMAN ANDERSEN: Our next speaker is Richard Foster, assistant professor in the Graduate School of Business and associate director of our program in health administration. A great deal of Richard's research and teaching efforts have been devoted to the topic of regulation. I find the title of his presentation, like Odin's, encouraging: I did not realize that we had a choice.

RICHARD W. FOSTER: Thank you, Ron. It is a special pleasure for me to be able to address this group on the occasion of the first symposium on hospital affairs to be held in the name of George Bugbee.

My assigned topic this morning is "Fork in the Road: Competition and Regulation." In contemplating this title, I cannot help but be reminded of that perennial favorite of academics, the fork in the road faced by Alice in Wonderland. You will recall that this particular fork was presided over by a Cheshire Cat. The Cat underwent such a remarkable series of transformations of its appearance that I am convinced that it was, in fact, a health maintenance organization.

In any event, exercising judgment comparable to that of the organizer of this symposium in asking me to speak, Alice asked the Cat which fork she should take:

"That depends a good deal on where you want to get to," said the Cat.

"I don't much care where—" said Alice.

"Then it doesn't much matter which way you go," said the Cat.

While I hope to leave you better informed than the Cat left Alice, I have a similar problem. My first task is to review how we got to the fork, and that is easy enough. Describing what lies down the road in each direction is more hazardous, but I shall at least repeat some popular beliefs. Finally, since this symposium is largely concerned with vertical integration, I shall speculate a bit on whether either fork is especially hospitable to vertically integrated systems. Since I find the nature of vertically integrated systems somewhat

mysterious, I may begin to resemble the Cheshire Cat at that point.

REGULATORY HISTORY

For most of this century, thinking about regulation in this country has been dominated by the "market-failure" approach. According to this view, markets are generally effective ways of allocating resources, but under certain conditions they produce perverse results. In these cases, government should intervene, either to replace market allocation or to regulate the market to correct its imperfections. The types of market failure and the conditions under which they occur have been elegantly elaborated.

No doubt you have all heard a recitation of a list of assumptions sufficient for perfect competition. The assumptions, of course, are never satisfied in the real world. Thus, according to the dominant market-failure perspective, there was always a case for government intervention.

In the early 1960s a subversive activity began. A small group of academics began to evaluate, empirically and carefully, the outcomes of regulation. The upshot of this was that what had long been taken for granted turned out to be false. As more regulation was evaluated, the accumulated evidence became more disturbing. The actual findings of the studies ranged from no effects to perverse effects. Often, the regulation seemed to benefit the regulated industry at the expense of the consumers it was intended to protect.

On the theoretical side, in the meantime, there was still little competition for the market-failure approach. Granted, there was still resistance to its application in particular circumstances. Granted, Ronald Coase published an important paper in 1960 showing that the most widely invoked cause of market failure need not cause markets to fail.¹ His argument assumed zero transaction costs, however, and, in the real world, it is always costly to arrange and carry out transactions. His work thus had little immediate impact in practice. It is of increasing importance, though, as modest progress is

¹Ronald Coase, "The Problem of Social Cost," *Journal of Law and Economics* 3, no. 2 (October 1960): 1-44.

made in delineating the nature of transaction costs.

The fatal flaw in the market-failure theory was that it was really only half a theory. It compared the real world with the theoretical ideal of perfect competition and, if the real world was found lacking, proposed to replace it with the theoretical ideal of a perfect government. What was needed, in addition to the theory of market failure, was a companion theory of government failure.

The development of such a theory is, alas, still in process. George Stigler's 1971 article entitled "The Theory of Economic Regulation" was an important step in this direction.² Stigler begins his article by noting that "the state is a potential resource or threat to every industry in society." The guiding principle in the new regulatory literature, of which Stigler's article is only a part, is that industries can be expected to try to insure that the resources of the state will be used to their advantage.

So far this amounts to no more than the pluralist view of government as an arena in which private interests compete. But there is more to the story. The new element is that the traditional economic approach of demand and supply analysis is brought to bear on the problem. Interest groups are thought of as having a demand for governmental favors, some of which may take the form of favorable regulation. On the supply side, the interest lies in what factors make such favors relatively expensive or inexpensive for various groups to obtain.

In the traditional regulatory problems, the relevant interest groups fall neatly into two categories: producers and consumers. On the demand side, producers are generally characterized by a more concentrated interest than consumers. For example, a rate hike of a few cents may be very important to a utility even though its impact on an individual consumer is quite small. Thus the utility can be expected to work harder to secure the rate increase than the consumer will work to oppose it. Consumers collectively, of course, have a strong interest in regulation. But the supply side also favors producers. They are already well organized, while it is very difficult (expensive) for consumers to organize in order to act collectively.

The result of this analysis is the prediction that regulation will usually, though not always, benefit the

regulated industry at the expense of consumers. The analysis can be refined to trace out the effects of differences in the elasticity of demand and supply in the regulated industry, the existence of prior regulation, and the more concentrated consumer interest that occurs when an industry sells its output to another industry.

This list of factors should be sufficient to illustrate that the approach is broader than its "capture theory" label suggests. I have already said that the theory is still being developed. While it appears useful in a broad way, its application to any particular industry still requires careful analysis of the situation in that industry. The theory provides only the beginnings of a cookbook for carrying out such analysis.

Despite its limitations, the theory has contributed to a growing skepticism about the effectiveness of regulation. This skepticism found a warm reception in the Nixon administration. There emerged an unprecedented phenomenon: a movement within government for deregulation. While this movement has hardly reversed the regulatory tide, it has scored some notable victories, particularly in the case of airlines. The movement has survived the transition to a Democratic administration and continues to grow.

REGULATION OF HEALTH CARE

At least until recently, the deregulation movement seemed to have little impact on health care. President Carter could, and did, in a televised address to the nation, applaud deregulation and, almost in the next breath, urge an extensive program of further regulation of hospital prices.

This distinction was not so odd as some critics tried to make it appear. Experts in the field, after all, had long argued that health care was "different"—in particular, that the market just did not work in health care. With only the beginning of a theory of when government succeeds and fails, one must surely argue that regulation is at least most promising in those areas where the market fails the worst. Health care is clearly a prime candidate. Milton Friedman recognized this in his book *Capitalism and Freedom*. He selected physicians as the example for his chapter on licensure, arguing that, if a good argument could be made in favor of licensure, it surely must be in the case of physicians.

Largely supporting a health care "exception" to the deregulation movement was the growing acceptance of a theory suggesting a new kind of "market failure"

²George J. Stigler, "The Theory of Economic Regulation," *Bell Journal of Economics and Management Science* 2, no. 1 (Spring 1971): 3-21.

peculiar to health care. This theory, first championed by Martin Feldstein, holds that the critical factor in explaining growing hospital expenditures, at least in the postwar period, has been the growth of insurance coverage.³ Furthermore, if one works through the technical economics, there is a strong case for the claim that, although the additional expenditures do provide some benefits, netting out costs and benefits will show substantial losses in welfare. This theory, almost totally outside the traditional market-failure arguments, was seen by many people as still more reason for regulation to contain costs.

Granted, not everyone accepted the insurance theory as an argument in favor of regulation. Some, including Feldstein himself, pointed out that much of the growth in insurance was encouraged or even mandated by government. An argument was made that what was needed was less government rather than more. Government should stop favorable tax treatment of health insurance, should restructure its own programs to eliminate first-dollar coverage, and should, perhaps, prohibit or otherwise discourage first-dollar coverage by others. These arguments, however, were generally dismissed as too radical to have any political prospects and, therefore, as irrelevant to practical discussions among men of affairs. I cannot resist pointing out that these ideas live on. Some alteration of the tax treatment of health insurance is now incorporated in "pro-competitive" legislation receiving increasing attention. And, when President Carter decided that his national health insurance program had to be implemented in stages and he faced the decision of what to phase in first, he opted for a catastrophic package similar in many ways to Feldstein's proposal.

On the other hand, two developments in recent years have made *competition* an increasingly attractive alternative in the health field. First, there is emerging a literature of careful evaluation of the effects of various regulations specific to the health field. In broad form, at least, these results are consistent with those found in other areas—the regulation has failed to achieve its presumed objective. The second major development was a change in thinking about the form which price competition might take in the health field. The image of the bewildered consumer trying to shop for the best price in physician services without much idea of how to

judge quality has long discouraged all but the most devout advocates of competition. With the emergence of the HMO strategy, however, the focus changed. Consumer price consciousness was now to be exercised at the level of the choice of a health plan. Instead of a myriad of prices, none of which he can easily learn and few of which he can know how often he will face, the consumer is confronted with a single price for a comprehensive package of services. Furthermore, since it is a *system* of care which is being considered, it is easier for the consumer to compare notes with other consumers on their experiences in that system. With the system rather than the individual provider as the unit of analysis, it should also be easier to generate more systematic quality information. Furthermore, it is in the interest of superior systems to publicize such information.

It is true, of course, that this must still translate itself into changes in behavior at the level of the individual provider and that the mechanisms by which this can be accomplished have yet to be clearly spelled out. However, at least the proper incentives seem possible. Once it is the system which is the object of evaluation, the strong links in the chain have an incentive to do more than ignore the weak links—their own reputations and livelihoods are jeopardized by allowing the weak links to continue unchanged.

PROSPECTS UNDER REGULATION

So much for history; what lies ahead? The dominant view, clearly, is "more regulation." But what would this more heavily regulated world look like? I believe that the insurance explanation of rising costs is of critical importance in anticipating future regulatory programs in the health field. It explains what you have all observed—that the pressure for increased regulation is coming from outside the industry.

This differs drastically both from the regulatory experience in most other industries and from the previous experience in health care. A good argument could be made that, until recently, regulation of health care conformed reasonably well to Stigler's model. It was sought by forces within the industry and was generally intended to improve quality. Such quality improvements were ostensibly for the benefit of consumers, and no doubt some consumers did benefit, but they served the interests of the industry as well.

Even the more recent health care regulatory programs

³Martin S. Feldstein, *The Rising Cost of Hospital Care* (Washington, D.C.: Information Resources Press, 1971).

do not fit badly with the producer-protection hypothesis. Certificate-of-need laws, for example, appear to protect the market shares of existing institutions without curtailing overall costs. While rate-review programs may have curtailed expenditure increases in some cases, their record across the board is unimpressive. Furthermore, they potentially benefit hospitals by providing an escape route from the Medicare cost formula and by equalizing the rates paid by various third parties.

The insurance theory, however, argues that concern for cost containment is more than rhetoric. As Professor Reinhardt pointed out last night, we have entered an era in which the United States no longer dominates the world economy. Although it is always hazardous to predict technological change, I hold the conventional view that medical science will not produce the silver bullets that enable us to consume all of the health services that are technologically possible without seriously disrupting other expenditure patterns. On the contrary, medical science will continue to discover new ways to deal with disease—at a price.

A reduced rate of economic growth, together with the expansion of technological possibilities, gives the fact of scarce resources an urgency in the health arena which it has previously lacked. It means that we eventually face some form of rationing of services. If insurance coverage prevents this rationing from occurring by means of prices charged at the point of service, other means will be employed. I am not saying that this rationing will happen easily or quickly—only that it will happen. The dominant ethic still holds that “needed” health services should not be withheld because of their cost. It is still true that provider interests are more concentrated than consumer interests.

The typical regulatory pattern of producer protection rests not on any inherently superior power of the industry, however, but, rather, on the lack of incentive for consumers to act. As costs continue to rise, consumer interest grows stronger. Once consumers become seriously concerned, their numbers give them the upper hand in the political arena.

Furthermore, the prevalence of third-party payment has facilitated the organization of consumer interests to an extent which is unusual in other industries. This can be seen not only in the concern of the Department of Health and Human Services but also in the growing concern of businesses about their fringe-benefit costs. In cities where the industrial base is relatively concen-

trated, further facilitating the organization of this consumer interest, private cost-containment initiatives have become important.

I am not arguing that rationing will inevitably be achieved through government regulation—only that this will occur if other means are not implemented first. Regulations *can* be written which will accomplish this purpose.

Such regulation will be arbitrary in many respects. The fact is that we simply do not understand health care well enough to agree on the right blueprint. Despite genuine improvement in our understanding, I doubt that we ever will. Absent such understanding, the only way to contain costs through regulation is with some sort of a cap. While arguments against the sensitivity of such a cap have been persuasive so far, the pressure for cost containment continues to build. Eventually, it will become strong enough that the arbitrary “unfair” fate of some providers will seem a reasonable price to pay. Some inefficient providers will be rewarded, and some efficient providers will be punished, but costs will be contained.

THE COMPETITIVE OPTION

The competitive alternative holds out the hope of a less arbitrary solution. It should not be assumed, however, that life is comfortable under competition. Businessmen are notorious for favoring competition in general but protection for themselves. Professor Reinhardt has labeled these “Type A Marketeers.”

In the first place, as I have already implied, competition is not really an alternative to regulation unless it achieves the rationing of services required by the reality of scarce resources. From the standpoint of the manager, the two paths are remarkably similar. Whether its source is competition or regulation, a powerful external force for cost containment confronts the organization. The manager must translate this pressure into altered behavior on the part of individuals whose personal interest in making these changes is only indirect.

There will be organizational failures under competition just as surely as under regulation; indeed, I believe that failures (or takeovers) are even more likely under competition than under regulation. I have already noted the tendency of many regulatory programs to protect established markets. Furthermore, not all of the failures under competition will be easily identified as inefficient organizations. Some will fall, for example,

and attribute the failure to their bad luck in being saddled with particularly recalcitrant medical staffs. The debate will continue about whether inability to control the medical staff is a component of inefficiency.

The difference in the two paths lies in the alternative available to the manager in trying to assure that his organization will be one of the survivors. Under competition, the provider must ultimately appeal to consumers. Under regulation, the appeal is to legislators and formalized rules. Notice that neither path allows the provider to appeal exclusively to professional judgment.

The appeal to consumers under competition, although mediated by competing health plans, is still relatively direct compared with the regulatory alternative. Legislators are concerned with consumers' health care preferences, to be sure. But many other factors will also influence their actions in health care. Providers will have to be sensitive to the full mix of legislator concerns to operate effectively under regulation.

Although some legislation will govern the terms of competition even if the competitive alternative is realized, it seems reasonable to expect that the range of permissible provider responses will be wider under competition than under regulation. Since consumer preferences are not uniform, this flexibility is likely to result in a greater diversity of organizational forms under competition than under regulation. Given the lack of both theoretical understanding and empirical evidence on optimal organizational forms, I regard this diversity as a positive feature of the delivery system under competition.

VERTICAL INTEGRATION AND THE FORK

What has any of this to do with vertical integration? I suppose the conventional wisdom is that vertical integration is the way to go regardless of which path is taken.

Down the regulatory path, it may be noted that the National Health Planning and Resources Development Act of 1974 specifically mentions vertical coordination as a priority. It is thus easy to believe that vertical systems will be treated more kindly by regulators than by individual providers. In the other direction, it is noted that the leading candidate to introduce price competition to the health field is the HMO, also the premier example of a vertically integrated system. It is easy to argue that a hospital which does not integrate and form its own HMO will be left out of the action. I am not so sure, however. Perhaps I am simply skeptical

because, as I mentioned earlier, I find vertically integrated systems rather mysterious. Indeed, it seems to me that the first issue to be addressed is whether what we call "vertical integration" in the health field is vertical integration at all.

Actually, these systems satisfy only part of the traditional criteria for vertical integration. It is true that vertical integration involves a merger of producers, with the downstream producer using as its input the output of the upstream producer. It is true that patients often flow from health care provider to provider in an analogous fashion. It is also the case, though, that the downstream producer generally purchases the output of the upstream producer. This is not really the case in health care. I am aware that there is still an analogy. I am even aware that the desire to guarantee referrals to the flagship institution is the principal motivation for some vertical systems. Traditional monopoly concerns may be relevant here. I am just not sure how far the analogy can be pushed.

Another view is that what we call "vertical integration" is really better described as diversification. Diversification may be sought as a means of organizational survival if the organization's original market is threatened or constrained. Hospitals, for example, may anticipate limited growth of acute inpatient care under either regulation or competition and, if growth is an organizational objective, may seek such growth in other markets. The recent diversification of the tobacco companies immediately suggests itself as an analogy.

It has also been suggested that growth through vertical integration will make an organization a stronger participant in regulatory proceedings such as those of the HSAs. It is unclear, though, why a geographically concentrated horizontal system would not be even better for this purpose.

I am sure there are still other reasons for integration or diversification and that some of these will be coming out during the remainder of the symposium. For the moment, however, I shall mention only one more. The most traditional motivation for vertical integration is the desire to alter the health care delivery process.

REGULATION AND INTEGRATION

With this as background, what are the prospects for vertical systems under regulation? Regulatory bodies

may operate on the basis of a variety of motives. If motivated primarily by a desire to preserve the health of the regulated industry, as suggested by much of the experience in other industries, they could render a strategy of survival by diversification unnecessary.

If motivated by the desire to benefit favored classes of consumers at the expense of other classes of consumers, as suggested by experience in some industries, vertical integration might be encouraged. It would broaden the base over which the costs of subsidizing "needed" services could be spread.

If motivated by some of the language of the National Health Planning and Resources Development Act regarding access to care, a regulatory body might encourage vertical integration as a means of improving availability and coordination of services.

I think I have made it clear, though, that I expect regulators to be motivated primarily by cost containment. On this score, I can find little beyond rhetoric to support vertical integration. Granted, the rhetoric has been sufficient to enshrine vertical integration in the official goals for health planning. But this is not sufficient to ensure favorable treatment of vertical systems. That will require evidence of cost savings. Perhaps such evidence is forthcoming. For the moment, however, with the exception of HMOs, we are running on little more than faith.

COMPETITION AND INTEGRATION

How, then, will vertical systems fare under competition? I have already remarked that HMOs have been the recent darling of the competition advocates. However, they are not the only game in town. Indeed, in the absence of a clear understanding of what makes HMOs tick, there is little reason to presume that they should be. Witness, for example, the IPAs. Do they count? How much can an HMO contract out and still be a "real" HMO?

The enormous range of variations among existing HMOs in the extent to which they contract for services reminds me to qualify my use of the term "vertical integration." In fact, a whole range of vertical linkages are possible, with vertical integration representing one extreme of the continuum.

To illustrate the point that HMOs are not the only game in town, consider an example near the opposite extreme of the continuum of linkages. This animal requires no formal linkages at all beyond the fact that some insurance agent has agreed to reimburse policy-

holders for services provided by any or all of a limited set of providers. This animal is called a health care alliance (HCA), and it is the latest sweetheart of many competition advocates. It operates not so much by managing the production process but, rather, by selecting efficient providers.

Imagine for a moment that the HCA rather than the HMO is the wave of the future. A vertically integrated system forces the HCA to make an all-or-nothing decision: either it reimburses for the whole package or it buys none of the package. Suppose now that you are an efficiently run hospital; will forcing the HCA into an all-or-nothing choice work to your advantage or disadvantage? I see no basis for a strong presumption either way. Suppose your well-managed hospital expands into new areas which it manages badly. The all-or-nothing character of the package will hurt the hospital's chances. Suppose, on the other hand, that the new activities are also well managed, though there is no particular symbiosis involved. Then the all-or-nothing character of the package should be a matter of indifference to the HCA. Finally, suppose that the various areas are all well managed and that genuine economies are realized through their integration. Then the HCA will find the package very attractive.

Of course, this last alternative is highly unlikely to occur in its pure form. If a fully integrated system is the most efficient form of production, there is no need for an HCA. The system can form its own alliance. In effect, the HMO emerges once again as the dominant form.

I note, however, that hybrids are also possible. If savings result from some kinds of integration, but not others, alliances could well emerge which covered services provided by a variety of partially integrated systems.

Is theory able to tell us much about which of these scenarios is the most likely competitive outcome? Unfortunately not, though here again it is trying. One popular approach is remarkably similar to the traditional theory of regulation described earlier. It recognizes that the essence of vertical integration is to suppress the market—to replace market allocation of resources with allocation by explicit management direction. It has been dubbed, appropriately enough, the market-failure approach to vertical integration.⁴

⁴Oliver E. Williamson, "The Vertical Integration of Production: Market Failure Considerations," *American Economic Review* 51, no. 2 (May 1971): 112-23.

It may seem that, just as the relative imperfection of medical markets represented an unusually strong case for regulation, so, too, it might present unusually favorable prospects for vertical integration. However, I have just described a revolution in thinking about the prospects for competition in health care, a revolution brought on by a realization that markets can operate at different levels. I am thus reluctant to write off the market as a failure too quickly.

Furthermore, this market-failure approach is potentially only half a theory. Management, too, has its problems. Just as an understanding of regulation requires a theory of government failure, so also does an understanding of vertical integration require a theory of management failure. Don't hold your breath.

CONCLUSIONS

So where does all this leave us with the fork in the road? I suppose I come down pretty much in the same

place either way. If vertical integration is an efficient form of production, it will prove advantageous regardless of the fork taken. If not, it is likely to prove a disadvantage.

I suspect that the competitive path will provide better discrimination between efficient and inefficient systems. Since I am unclear about the efficiency of vertical systems, however, this still provides little definite direction.

I hope I have not carried this Cheshire Cat thing too far. As an academic, I have the luxury of looking at a confusing world and being amused by it. I understand that most of you must act in spite of the confusion. I hope my remarks can contribute to better-informed actions. They are not intended to deter such action.

General Discussion

RONALD M. ANDERSEN, CHAIRMAN

CHAIRMAN ANDERSEN: We have a few minutes for questions.

RICHARD JOHNSON: Rich, I would like to ask you to comment on something that I did not understand: the definitions of the words "industry" and "regulation." It seems to me that you avoided discussing the fact that we have an industry with lopsided controls: There are controls on hospitals and nursing homes but not on physicians, dentists, or drugs. Therefore, I guess I missed the point of your discussion when you talked about a vertical system being able to suppress something, because when you have lopsided controls, those people who are controlled opt out for the unregulated side.

RICHARD FOSTER: I understand your point about lopsided controls. I clearly do not expect that that situation will persist indefinitely.

MR. JOHNSON: That is a major difference between us.

ODIN ANDERSON: You think that lopsided controls will persist?

MR. JOHNSON: I do not think that they will ever nail physicians, so I think that's the problem.

PETER SAMMOND: Odin, in your exposition, it seems that you are taking off from 1980 and making your projections for 1990 as if there is no excess in the present system and supply of services. First of all, is that accurate? Then I would ask Rich whether he agrees with that ten-year projection of Odin's, because Rich seems to be saying that controls or competition will be more effective.

MR. ANDERSON: I will answer your question at the risk of your accusing me of avoiding it. I do not know what "excess" in the system is; so far its determination seems to be arbitrary. How do you know if 5,000 beds in Chicago, or 100,000 in the United States, are excessive? I can go further: I think that half of them are excessive; we could live without them. So I pay no attention to "excessive" or "inadequate." What interests me is the equilibrium we reach with whatever we have at any point in time. Is that politically tolerable? Is it tolerated by the profession? Is it tolerated by the consumer? Is it tolerated by the funding agency? I do not use the word "excess."

MR. SAMMOND: But you seem to be saying we will tolerate the level that we have now and build on that. I guess I do not agree with that.

MR. ANDERSON: We may, in fact we undoubtedly will, change the mix, but I would see an increase. We will probably sit on the hospitals and not increase the number of beds, and then when the population increases, lo and behold, we will have just enough beds. It is a matter of what we want. Do you think we have an excess? And if so, why?

MR. SAMMOND: I do, and I hear the industry and the people who are paying for a great deal of health care also saying that we have an excess, and they are beginning to act, to do something about it.

MR. ANDERSON: Are you going to reduce the excess by regulation?

MR. SAMMOND: That gets into another argument, but I think that it can be done.

MR. FOSTER: I agree that it is difficult to identify excess, but I do not think it is quite that hopeless. I think the key is the separation between consumers' individual choices and collective choices that occurs through insurance, and that might provide a mechanism for excess, even if it is difficult to say whether the right number is 4.5 or 4.6 or whatever beds per 1,000. So I am inclined to think that there is an excess.

I do not know about Odin's prediction for the next eight years. I am somewhat skeptical, but it may be right. As I say, I do not know how quickly this thing is going to happen.

MR. ANDERSON: If I am right, I will not know why.

MR. FOSTER: If you want to extrapolate that rate beyond the next eight years, I will be willing to agree more unequivocally.

ALEX HARMON: In this discussion about whether we have too many beds, I think we are talking in terms of current conditions, while at the same time we are trying to project for the future. I have not heard anyone suggest that there might be a changing requirement for beds, such as an aging population which requires more health care, so I was wondering if anyone could comment on the impact of that on the need for beds in the future.

MR. FOSTER: I will agree that the aging population means we are going to need more beds in the future, but I am not willing to say anything more specific.

MR. ANDERSON: I would say we can expect change in the types of beds and their location, from acute hospitals to nursing and convalescent homes.

MR. HARMON: Except that Medicare patients stay acutely ill longer, and they are going to be in greater numbers. They are going to need more acute care for longer periods.

MR. ANDERSON: I think so. This is my intuitive projection: We will have hospices and hospice beds.

MR. HARMON: Those are not for the acutely ill but for the terminally ill.

MR. ANDERSON: Well, they are pretty sick. They are not acutely ill, but they are pretty sick.

MR. HARMON: Many of them are in their homes, not in health care facilities.

CHAIRMAN ANDERSEN: Alex, don't you think there is a big area of discretion here in defining whether an aged patient is acutely ill or chronically ill? There are many arguments made about the inappropriate—if Odin will allow me to use the term—use of the acute hospital and the ability to move these people somewhere else where they do just as well.

MR. HARMON: I think that sort of fortifies what I was saying: We are going to have to think about all these factors when we are trying to predict what kinds and number of beds, where they ought to be located, and for whom. That has to be part of our thinking.

Vertical Health Care Systems

ROBERT L. MONTGOMERY

CHAIRMAN ANDERSEN: As Rich Foster pointed out, much of our symposium, in terms of considering managing for growth and future expansion, has to do with vertical health care systems. And I must say I also find this title encouraging. To kick off this next part of the symposium, we are very pleased to have Robert Montgomery, executive vice-president of Alta Bates Hospital in Berkeley, California, who will discuss "Vertical Health Care Systems," with specific emphasis on marketing.

ROBERT L. MONTGOMERY: Thank you, Ron. It is my pleasure to be with you today and to participate in your twenty-second annual symposium. It has also been a pleasure for me to meet Odin Anderson, some of whose articles I remember having read when I was a student at the University of California, Berkeley, and was taking a graduate course in sociology of occupations and professions.

The 1960s have been characterized as the years of increased health insurance, increased specialization, and increased technology. In the seventies, as we have heard here today, this naturally led to increased use of health services, increased costs, and increased government emphasis on and regulations for containing health care services expenditures. In the 1980s we can expect significant changes in how health services are organized, paid for, and delivered. Many of these changes will be made in an effort to help hold the line on expenditures for health care services. Multihospital systems, consortiums, vertically and horizontally linked organizations, and HMOs are all part of our cost-containment, antiregulatory effort. This is an important stage in the history of the development of our health care system. For example, anyone who has studied some of the health systems in other countries realizes how unique the HMO movement is, particularly the notion of having those who *provide* the service, rather than outside regulatory agencies, ration the service.

My assignment is to discuss the vertical health systems with an emphasis on marketing. For purposes of

this presentation, I define *vertically linked* patient care programs or separate organizations as those which are under some common governance or organizational structure for the purpose of organizing and delivering services and allocating the resources in a more coordinated, cost-effective manner. These programs or separate organizations may be in the hospital, on the hospital campus, or in the hospital's market service area. Another term worth clarifying is *marketing*. The marketing system of a hospital has a number of elements: the information collection and analysis section, the planning component, the communications and promotional components, the public and community relations elements, and marketing operations. Today I will concentrate on the planning components of marketing as they relate to vertically linked programs and organizations.

There are several prerequisites for the development of an effective vertically linked health system:

1. The chief executive officer must realize that a major portion of his or her job is to *lead* his or her organization in adapting to the changing political, economic, scientific, regulatory, and competitive environment with all of its crosscurrents and challenges. In marketing terms this means influencing the buying publics—physicians, patients, and employers—to utilize the health services one is providing in sufficient quantity so that the organization can gain a significant enough share of the market to assure the program's quality and economic viability for the long term.

2. The chief executive officer needs sufficient staff to handle day-to-day operations if he or she is to have the time to think and plan and exercise leadership of the corporate planning process. For example, I built a system of working with residents from the University of California program in hospital administration to insure a continuous flow of new, young people into the hospital; it was easy to keep moving them into planning positions and to, in essence, build an administrative bureaucracy that freed the chief executive to do the necessary planning.

3. The organization needs a planning process that is continuous, timely, agreed upon, and built into the

board of trustees', the medical staff's, and the management staff's decision-making and communication processes. No matter what you are planning, you must be able to coordinate your plans with these other groups and develop in them a commitment to the planning program you have adopted.

A good planning program, we have found, has different stages: strategic planning, with a time framework of ten to fifteen years; tactical planning, with a five to ten-year time framework; and current objectives, with a one to five-year time framework. These stages should result in a clear statement of the hospital's purposes, goals, and objectives, which in turn can be related to and integrated with day-to-day hospital operations. Without such a planning process, it is extremely difficult for the chief executive to avoid being diverted in many directions by various programs in the organization, with the result that he or she may lose sight of the importance of a planning process as an effective management tool in leading the organization.

Let me focus on how we utilized a marketing systems approach in developing some twenty-five to thirty vertically integrated patient care programs over the past ten years at Alta Bates Hospital, as well as the development of five other related organizations, including nursing homes, a commercial laboratory, an HMO, and so forth. This process has worked reasonably well for us; over this period of time, we have been able to increase our bed capacity from 200 to 350 beds and maintain 85 percent occupancy, we have decreased our length of stay from 9.5 to 6.5 days, and we have increased our outpatient visits from 45,000 to 145,000. We have a coordinated system of some 650 nursing home beds that provide for easy transfer and coordination of care.

All in all, the result has been a product mix of vertically integrated services for patients and organizations that has resulted in a strengthening of our organization's finances. Each of your hospitals and their environments are a little bit different, and, therefore, your adaptations will vary. The specific programs which we have developed are not that important; what is important is the *process* that one can follow in order to have a framework in which to exercise leadership in the organization and change of the health care delivery system.

The first step is the development of a strategic program plan that projects your future environment in

terms of such items as demography, health services, and patient care needs, on the one hand, and the alternatives for your long-term adaptations to that environment, on the other. We update our strategic plan every five years. Our 1970 and 1975 plans included the following major conclusions:

1. The desirability of establishing a comprehensive health care delivery system for our geographic area that assures that we look at the health care needs of people and coordinate the organization and delivery so that it is of high quality, accessible, and coordinated. This is quite different from having limited hospital objectives providing only hospital care and service.

2. The recognition that the cost effectiveness of a local comprehensive health care delivery system would be facilitated by linking the parts through an economic mechanism; this later stimulated our HMO development. We are right next door to Kaiser and have seen the growth of that prepaid health plan; today it captures 35 percent of the total population in our service area. Because of Kaiser's dominance of the market, they are starting to control prices in health care delivery.

3. The commitment to maintain our economic viability, namely, the need to obtain a return on equity equal to the increased rate of inflation, the need for working capital, and the need for funds to cover the increased growth of technology, which equals 7.5 percent of operating revenue. This led to the development of related organizations to generate income, that is, a foundation, nursing homes, a commercial laboratory, and other for-profit ventures intended to generate funds from sources other than patient care program operation. This strategic plan also indirectly supported the HMO program concept as one way to decrease our dependence on government-pay patients with all the related reimbursement problems.

We update each strategic plan and its related tactical and short-term goals and objectives, and as we do, these stages evolve, merge, and "synergize" each other. Tables 1 and 2 and figures 1 and 2 are by-products of our marketing planning process over the years and, specifically, of our strategic plan update in 1979. Let me highlight a few points contained in these tables and figures as they relate to the formation of vertically linked health programs, organizations, and systems. Please note the strategic marketing questions of table 1. Our

approach in planning is not simply to take a trend and project it; rather, we ask questions, some examples of which follow:

The first question is, what is the most useful way to define the health care market? Our answer to this involves the development concept of *target groups* (see table 1). Target groups define subsets of the population on the basis of nonhealth characteristics which predict what services they will demand of the health care system. Target groups are based on such variables as age, sex, income, degree of mobility, education, or type of insurance coverage. Examples of target groups

would be the aged, young nonprofessional athletes, or the working population; a major target group is composed of the patients of physicians on our medical staff. Target groups as a development concept enable the doctor and the hospital to focus programs on the specific service requirements of the group and to achieve early acceptance of programs and high rates of utilization. Within each target group, there are "risk groups," defined by health or disease characteristics, such as arthritic persons, alcoholics, or heavy smokers. Thus, under this concept, one could develop, for example, a sports medicine health clinic to meet the

TABLE 1

ALTA BATES' MARKET AND PROGRAM DEVELOPMENT CONCEPTS

Strategic Marketing Questions	Development Concepts
What is the most useful way to define the healthcare market?	Target Groups
What are the most important disease/health characteristics of the market?	Chronic Disease Prevalence
What are the relevant nonhealth characteristics of the market?	Variety of Lifestyles
Who serves the market?	Hospital-Physician Partnership
What is the best way to deliver services to the market?	Packaged Programs
What desirable payment mechanisms can be devised?	Local Funds Flow
Who can best devise service plans and set policy?	Provider-Purchaser Alliance
What form of hospital organization best responds to the market's needs?	Matrix Organization
How should health manpower be distributed and deployed?	Multiprofessional Practices
What tools and techniques can the hospital use to reach the market?	Target Group Liaison
How can the hospital maintain both quality of care and cost effectiveness?	Protocols
How can the local healthcare delivery system function better at all service levels?	Organized Health Care System

NOTE. — Summary of strategic marketing questions and development concepts. Analysis of the scenarios of hospital alternatives identified the development concepts which answer fundamental questions about Alta Bates Hospital's market and provide the basis for the strategic game plans. Specific scenarios associated with each concept appear in table 2.

SOURCE. — Adapted from Alta Bates Hospital's Strategic Plan, exhibit A.

TABLE 2
INDEX TO CONCEPTS AND RELEVANT SCENARIOS

CONCEPTS	SCENARIO TOPICS												
	Aging Population	Changing Sex Roles and Lifestyles	National Health Insurance	Rate Setting	Capital Financing	93-641 and 4001	Medical Profession Developments	Health Technology	Organization of Local Health System	Program Development Concepts	Funds Flow	Authority of Corporation	Local Economic Political and Cultural Environment
Target Groups	X	X	X	X		X	X		X	X	X		X
Chronic Disease: Pre- and post-acute disease management	X	X	X	X			X	X	X	X	X		
Variety of Lifestyles	X	X				X							X
Hospital-Physician Partnership		X	X	X		X	X	X	X	X	X	X	X
Packaged Programs	X	X	X				X	X	X	X			X
Local Funds Flow			X	X	X	X			X	X	X	X	X
Provider-Purchaser Alliance			X	X	X	X			X		X	X	X
Matrix Organization		X				X	X	X	X	X			
Multiprofessional Practices	X	X		X				X	X	X			X
Target Group Liaison/Protocols	X	X	X	X		X	X	X	X	X	X	X	X
Organized Care System			X	X	X	X	X	X	X	X	X	X	X

SOURCE.—Adapted from Alta Bates Hospital's Strategic Plan, exhibit B.

needs of young nonprofessional athletes or an arthritis and rheumatology program to meet the needs of the aged.

Our answer to the second question, What are the most important disease/health characteristics of the market? is the development concept, *chronic disease prevalence*. If the proportion of people with an underlying or obvious chronic disease is high in the target group served by your institution, there are opportunities for service that extend beyond the acute-care phase of illness. Examples of intervention are high-blood-pressure screening clinics, outpatient arthritis programs, or pulmonary and cardiology rehabilitation programs.

To the fifth question, What is the best way to deliver services to the market? we answer, *packaged programs*. Each of these is a planned series of services designed for a particular target or risk group which is delivered specifically to that group. One example is a cardiac care program for the members of the group at risk of heart disease and people who already exhibit symptoms. The package could include risk screening and identification, a sequence of exercises, nutrition information and counseling, multidisciplinary evaluation of serious cases, acute medical management protocol, surgical protocol, post-acute and cardiac rehabilitation, and a cardiac patient family club or group maintenance organization. Packaged programs extend health care services to the pre- and post-acute phases of health needs.

Further down the list, we ask, How can the local health care delivery system function better at all service levels? And we come up with the development concept, *organized health care systems*. An organized health care system ties the parts of the delivery system together for better overall results for the provider and the patient. The current economics of health care are both cause and effect of the differentiation of health services into separate providers and organizations which specialize in one or a few services at a narrow range of the acuity spectrum. Each provider seeks to maximize its own revenue in competition with other similar organizations. There is little or no means of reallocating resources from one part of the system to another because organizational ties between units of the system are weak at best. These shortcomings can be overcome by vertically or horizontally integrated units or, in the long run, a combination of each type.

Table 2 is a matrix that combines our development concepts (see table 1) with scenario topics which repre-

sent the different forces acting on our particular health care environment. This helps us forecast our future environment and develop the appropriate strategic marketing questions and concepts that can aid in our adaptation to that environment. However, note that in our planning we do not project a trend or trends but a great number of variables. Our society as a whole and, in particular, the science and technology with which we work in our field grow and change at phenomenal rates. If we look at a full range of environmental variables or topics—from an aging population to local politics, economics, and culture—we are in a better position to adapt to this growth and change.

For example, take the topic of the organization of local health care systems. Figure 1 provides an example of our analysis of that force in our environment and how we define a problem, alternate scenarios, and implications for hospital and organizational responses. This approach allows us to add new forces as they emerge and to update existing scenarios as indicated. Here we view as problematic the loss of local decision-making power, because errors are probable in decisions made at a distance and, in addition, local institutions lose incentives to progress, lose good people, and so forth. From the problem we move to alternate scenarios, from the status quo to possible future developments. For each scenario we describe the implications for hospitals and the organizational responses. From the latter, we develop our planning program in all its parts.

Figure 2 is an example of applying packaged program concepts in pulmonary medicine to a high-risk subgroup within a larger target group. Note that the packaged program concept deals with the pre-acute, acute, and post-acute phases of illness as well as the three levels, primary to tertiary, of vertically integrated program services. Note also the two lines or curves on the pulmonary medicine program: The line beginning at upper left is the patient or population line; the other line describes resources. At the upper left you see individual need: Many people could benefit from early pulmonary disease prevention; that number of people decreases in the acute phase but increases in the post-acute or rehabilitative phase. The resource curve shown where we spend our money: not on prevention (pre-acute phase) but in the acute phase. You can also see in figure 2 the complete and well-coordinated services we provide at each phase.

All of this requires an effective means of tying things

<p>TOPIC: 6. ORGANIZATION OF LOCAL HEALTH CARE SYSTEM (LOCAL FOCUS)</p>	<p>ALTERNATIVE SCENARIOS</p>	<p>IMPLICATIONS FOR HOSPITALS</p>	<p>ORGANIZATION RESPONSE</p>
<p>PROBLEM/ISSUE</p> <ul style="list-style-type: none"> Initiative for decisions about the local health-care system comes more and more from the top down. (See Health System Structure chart attached.) This means decisions are made at ever greater distance from where patients are actually served. With increasing distance comes increasing rate of error and magnitude of mistake. The problem for institutions is loss of incentive to lead or progress, loss of good people, and failure to achieve professional or service goals. Problem, too, is that governance level is bypassed as top-down controls are placed on service level. 	<p>STATUS QUO</p> <ul style="list-style-type: none"> Direction of Development — top down, from public policy and paper down thru service level via regional structure Type of power is law Purpose of organizing — limit capital investment Sponsor — Federally sponsored planning agencies; scope — provider capital and service decisions Impact — “freezes” health system and adds superstructure with little value 	<ul style="list-style-type: none"> Puts hospital on defensive Creates automatic conflict situation w/ supra-authority, which claims to be working in public interest, therefore must be against provider interest No continuity in rules hospitals live by Makes hospitals more competitive with each other 	<ul style="list-style-type: none"> Gain strength through superior knowledge Seek separate public support Challenge arbitrary decisions that could become precedent Modify competition through peer level cooperation
<p>INDICATORS OF CHANGE</p> <ul style="list-style-type: none"> Percent of hospital-level decisions affected by outside authority Nature and importance of delivery problems that cannot be solved at local level. (lack of intermediate care level, for example) Percent of management and professional time spent in approval, negotiating, or legal process Number of outside agencies with some authority over hospital decisions Basic indicators, hospital financial strength — pre-Medicare, 1970, 78 and continuing Cost of regulation Estimated total underpayments, Federal, state programs, to local system 	<p>LIKELY</p> <ul style="list-style-type: none"> Direction top down Power — law and money — grants and payment Purpose — plan capital and other resources and assure service availability Sponsor — Federal and state Scope — capital and service, user choice 	<ul style="list-style-type: none"> Loss of ability to manage institution's assets and resources Uncertainty as to actual results due to delays in final settlements Drive private cap from market due to pay back uncertainties — replaced with state source — more power to state 	<ul style="list-style-type: none"> Budget for legal fees Join advocacy organization Develop programs not requiring capital Develop alternate organization to own capital accounts
<p>LIKELY NOW & LATER</p> <ul style="list-style-type: none"> Direction — bottom up Type of power — knowledge — technical and professional service Purpose — coordinate service operations among providers serving same patient Sponsor — provider consortium Scope — provider capital and service decisions Impact — reduces expenditures and corrects long-standing problems 	<p>LIKELY LATER</p> <ul style="list-style-type: none"> Direction — bottom up Type of power — money (local funds flow), knowledge, public knowledge Purpose — manage capital investment, coordinate service operations, plan and develop resources, create public policy and advocate it Sponsor — multi-institutional system holding company or provider-purchaser organization Scope — all major provider decisions, and purchaser benefit, coverage decisions and user decisions Impact — corrects long-standing problems, gains acceptance and improves ability of health system to change and perform better 	<ul style="list-style-type: none"> Mandated services as condition of approval for desired services Longer lead time on approvals Litigation between providers for franchising rights Increase rule-making re: appropriate placement of patients 	<ul style="list-style-type: none"> Develop tie with defined market for justifications of services Develop plan now for vertically integrated service system and seek public support to test new services Link with other providers to reduce conflict
<p>POSSIBLE LATER</p>		<ul style="list-style-type: none"> Some voluntary sharing of power and resources to gain strength through association Hospital organization assumes some planning responsibility for local system — with advocacy to agencies or payers Internal stress between board and management and MD's who resist organization or compete with it 	<ul style="list-style-type: none"> Provide leadership and support Resist competitive moves that would destroy trust Strengthen institutional planning to create better area plan
		<ul style="list-style-type: none"> Share power with purchasers Act on part of a total delivery system Gain local autonomy at price of reduced institutional autonomy Necessity of meeting both institutional and public expectations — greater emphasis on research and development and public information Hybrid organization — holding company for hospital — separate management Physicians participate as contractors as part of management cadre 	<ul style="list-style-type: none"> Provide leadership and support Study and relate to business community Create common data base and analysis capability Free chief executive officer to work in local system Organize physician corporation for recruitment and contracting.

FIG. 1.—Analysis of scenario topic (organization of local health care system) from perceived problems to organizational responses. (Adapted from Alta Bates Hospital's Strategic Plan, exhibit C.)

together and making our plans operational on a day-to-day basis; this is where the hospital's statement of purpose, goals, and objectives comes into play. Over the years, our statement of purpose has changed as we have adopted new concepts from our strategic planning; our goals statements have also changed as a result of our short-term tactical and objectives planning. For example, we began to realize that our focus has moved beyond the *hospital to related organizations*, and not to related organizations as individual units but as part of a coordinated health care delivery *system*. While each of our packaged programs may be developed for a specific target group and may meet their individual needs, the programs, when taken as a whole, develop a certain amount of synergy and become vertically linked with other programs to provide a comprehensive range of services. For example, the development of our home care program was a natural outcome of our effort to provide the outpatient and rehabilitative service components of cardiology and pulmonary services. Home care, in turn, is a natural building block for our hospice program for the terminally ill. Our patient-education program serves people from many specific programs in pre- and post-acute phases. The coordination and synergy of vertically linked patient care packaged programs results in the best organization of services and allocation of resources into an effective delivery system.

Up to this point, I have outlined a planning process that results in a framework for developing vertically linked and integrated patient care programs; the same process also works for vertically linked and coordinated separate organizations of health services. For example, the development of nursing homes and, in the future, retirement centers under separate organizations will allow us to extend our care for the patient from the acute hospitalization phase to the post-acute phase. On the other end of the spectrum, the establishment of a separate corporation for handling ambulatory services will allow us to meet the pre-acute phase of a person's health needs in an effective manner. Programs that are being grouped under this organization for certificate of need, reimbursement, and operational purposes are our commercial laboratory, sports medicine clinic, and home care and hospice programs. In the future, occupational health, support packages for nursing homes and retirement centers, and health equipment rentals will be in this organization. Vertically linking patient care in packaged programs and separate organizations will

allow for effective allocation of resources. When you tie an HMO concept into this, you can begin to provide coordinated care, easy access, and high-quality service at the least cost for the people you are serving.

Hospitals that have developed comprehensive vertically linked and, perhaps, horizontally linked services will begin to link themselves with other similar organizations in the form of either vertically linked or horizontally linked health systems. This will all be part of the reshaping of the organization and delivery of health services through the development of consortiums, multi-institutional health care corporations, and so forth.

I have emphasized the *planning* component of a marketing system for vertically linked patient care programs and organizations because unless you design a good product, it is difficult to sell. However, we make an effort to give adequate attention to the other components of a marketing system which I mentioned earlier, such as information and community relations.

Our marketing group—made up of the administrator of the hospital, director of public relations/marketing, and the director of data processing and information—coordinates our total marketing system. This group ensures that we have the necessary information system to obtain patient data on our publics—physicians, patients, other referral sources, and, in the future, major employers who will be utilizing our HMO program. Without good information and feedback from these same publics, it is difficult to carry out good research and development, which is the initial stage of the planning activities or product development described previously.

If the health care delivery system operates with good information, planning, and product-execution systems, then another part of the marketing system, namely, communication, advertisement, and community relations, is frosting on the cake. Nevertheless, it is important, and you have to present and promote your services in specific ways to accomplish your overall organizational and strategic objectives. Again, our promotional and sales material is aimed at our buying publics. For physicians, we offer orientation programs for new physicians, physician office manuals on how to use the hospital and our packaged programs, and orientation for physicians' secretaries to our business office and admitting practices. In addition, representatives from our commercial laboratory visit physicians' offices, describing lab services and prices. In short, we involve

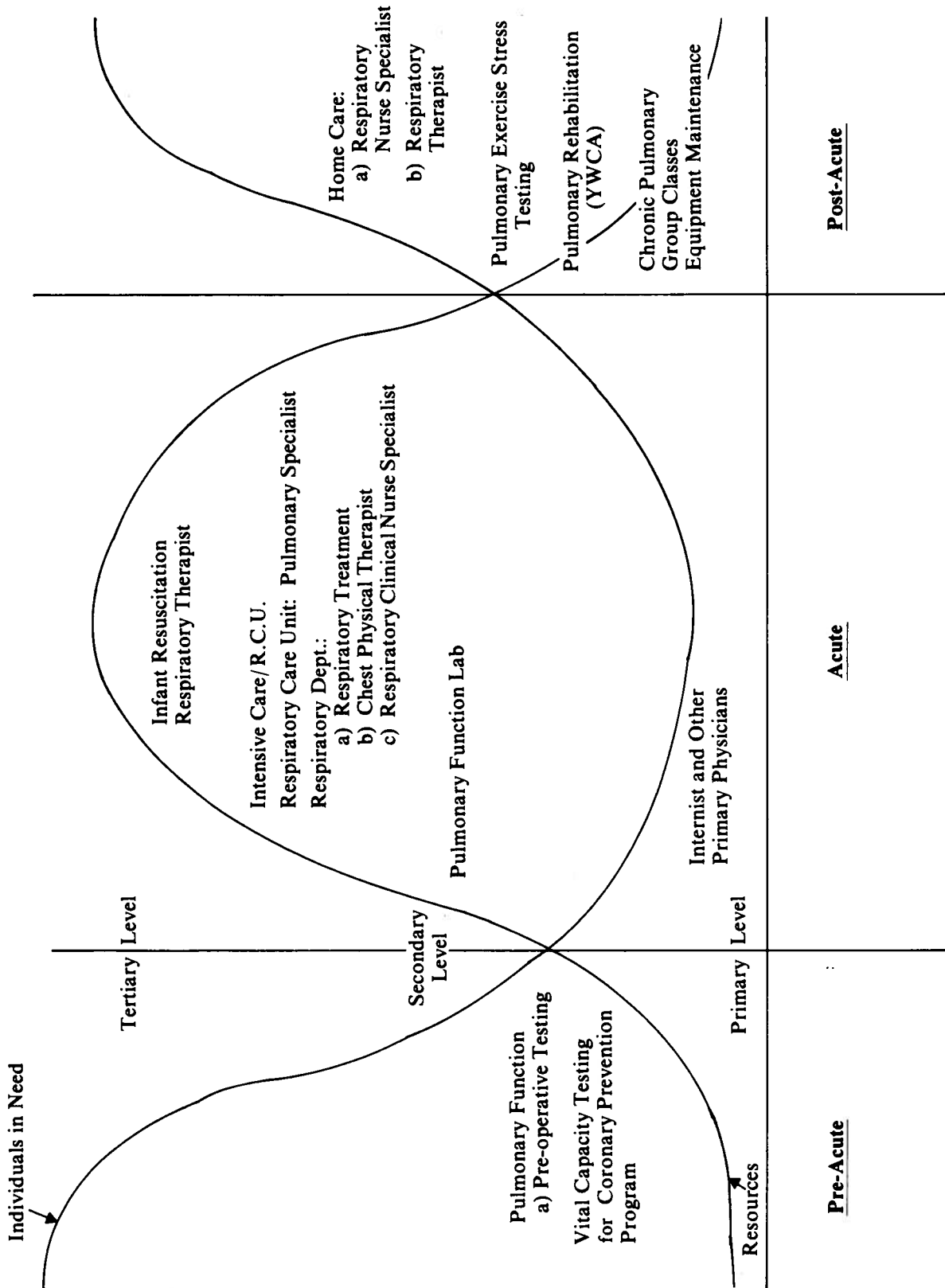


FIG. 2.—Health care system spectrum: completeness of program—pulmonary. (Adapted from Alta Bates Hospital's Strategic Plan, exhibit D.)

physicians in the planning of our program activities and we assure them of quality care, facilities, and equipment; thus it is easy for them to utilize our services at whatever phases their patients require.

We try to convey to patients that we are a full-service organization for their particular health needs and that the services are of high quality and are coordinated for their easy access and effective and efficient use. "Concern for care," the hospital's motto, is what we try to emphasize on an individual basis at all levels. Although we plan and operate a total health care delivery system, in addition we always keep in mind the individual patient and his or her immediate needs.

Like most organizations, we provide a wide range of publications, community education programs, speakers' bureau, "tel-med," health education exhibits, radio spots for the alcoholic rehabilitation program, and so forth. Our effort is to let people know what we do and how they can use us. We firmly believe, though, that our best advertisement is a good product provided in an effective, coordinated manner by employees and physi-

cians who enjoy working in and as part of the hospital's health care delivery system.

While my part in this program has been to emphasize the marketing aspect of vertically linked health care systems, other speakers will cover the organizational structure, the economics, and the management of such systems. Without the proper implementation of these other elements, the marketing system, strong as it may be, will not reach its potential.

In the 1980s we will witness many changes in the organization and delivery of health services. Vertical linking of patient programs and entire health care systems will be an important part of this restructuring. As leaders of health care institutions, you have the training, experience, and opportunity to meet these challenges and see that the changes and restructuring work best for your institutions and the health care field at large. We will be successful if we keep one eye on the future and build good marketing and planning systems which will help us avoid developing sophisticated solutions to yesterday's problems.

General Discussion

RONALD M. ANDERSEN, CHAIRMAN

CHAIRMAN ANDERSEN: We have a few minutes for questions.

MEMBER: In marketing your preventive programs, do you rely basically on your staff physicians for referrals or do you go to outside sources?

ROBERT L. MONTGOMERY: We go to all available sources. We analyze who our referral source is, so if it is a pulmonary disease, we would naturally market to physicians, but we would also go to the TB association. We go to those organizations that are likely to be involved in caring for people with that kind of problem.

MEMBER: For something like your sports medicine clinic, whom did you go to for referrals?

MR. MONTGOMERY: If you want a program to be successful, you must involve the people at the beginning so they will be there and buy the service from you at the end. So in the case of sports medicine, we started by going to the coaches, running clubs, and athletic clubs where they have a large number of people who might use that service, and we involved them in planning it. What price would people pay? What is the nature of the service they want? How accessible does it have to be? What should be its hours of operation? How does it fit in with the referral service? And then we designed a program to meet those needs indicated by the people. Then the marketing of that followed naturally: We just followed up, with such things as brochures, those whom we involved in the planning process.

MEMBER: You mentioned the Kaiser group had 35 percent of the market, and I think you said it was your major competitor. Do you attempt to compete with Kaiser on a head-to-head basis?

MR. MONTGOMERY: We plan to compete with them in terms of organization and access on a head-to-head basis in the nine-county area, by linking together HMOs of comparable design and structure to assure access and marketing. In terms of price, no. We are pricing our product at 15 percent above that of Kaiser, but having to hold to 15 percent above Kaiser means that getting these programs off the ground, the physicians have to take about what the state pays for Medicaid, which is about sixty cents on the dollar. But we have convinced them that, unless they get in there now and start working with us to change the mix in their

practice, they are going to have a very difficult time in the future. We go 15 percent above on the basis that we are trying to provide more service. In our program, people are able to select their individual physicians, so we are shooting for that slice of the Kaiser market made up of the generally higher-income persons who are willing to pay a little more for the service if they can go to their own physicians.

MEMBER: But you do not attempt to sell HMO-type coverage, do you?

MR. MONTGOMERY: That is exactly what we are doing: We will be operational January 1, 1981, with a full, qualified HMO program. We initially started out ourselves but realized that we could not survive over a five-year period in the marketing and pricing side of the market without creating a network, so we went out and got ten other hospitals in our 2 million population-base area and their medical staffs to join with us in a hospital-based, physician-based HMO network, and then we linked that with other networks, so that we could go to the big employers in San Francisco and elsewhere with a common marketing, common benefit and price structure to compete with Kaiser.

MEMBER: I am assuming that, for your various marketing packages, you are using personnel who have prime responsibility for inpatient services as well, is that correct?

MR. MONTGOMERY: Yes, partly, although we are starting to get away from that.

MEMBER: You are starting to have people who are devoted solely to marketing? For the people who you are using in that dual role, what kind of financial incentives do you provide for them, to get them motivated to run with you in this program?

MR. MONTGOMERY: Unfortunately, we do not have any financial incentives; it's just good old motivation and pride in doing a better job..

One management philosophy I have had up to this point, but it has now broken down and we have to change it, is to build into each job, whether it's an assistant administrator job or department head job, a fair amount of latitude, of scope and responsibility, so a department head in our organization must worry not only about budget but also about his market, for exam-

ple, not only how many patients he's going to serve in cardiology, but also where are they going to come from? What kind of new groups is he going to go out to? What is his brochure going to look like? Each department head has a small marketing part in his or her job. The problem is, as things get bigger and more complex, they cannot do all the marketing any longer, so now we have to start backing off and we need to create a specialization in our management structure to carry it out. We have an individual in our public community marketing relations side who works with all the department heads to keep them conscious about market development.

MEMBER: So up to this point, you have assumed there is enough slack in the position to devote to the marketing program?

MR. MONTGOMERY: We do not consider it slack; we think it is just part and parcel of their job. That is, if they are going to budget for so many patients in the cardiology lab or the pulmonary lab, they have to know where those people are coming from. You just cannot sit back and assume they will be walking in the door.

MEMBER: Bob, do I understand you to say that you have in your strategic plan a geographic limitation as far as the development of programs and plans? You said nine-county area. In other words, if somebody came to you and wanted to link in any way from northern California or southern California, at the present time you do not see that in your plan?

MR. MONTGOMERY: Yes, we have geographic boundaries. My philosophy here is that we are trying to do a better job for the people we're serving, and we're only going to be successful in broader linkages to the extent to which we continue to do a good job with the people in our immediate area. Now, there is no question in my mind that we will link up with other vertically integrated systems such as our own in the future, and those may very well carry us well beyond this geographic area, but that linkage would be for certain kinds of referral patterns and economic patterns. That linkage should only take place if it really results in benefits for the local organization and the local community we are serving. We are not in the business to make money. If we were, we probably would not even be in the hospital business.

JOHN BETJEMANN: One of the problems we run into is that the exciting things that develop in these new ventures cannot be managed by the company because the company hasn't built in the management mechanisms to run effectively what was created. How have you dealt with the issue of making sure that your management

mechanisms—classical, dull, day-to-day pedestrian management—can cope with the new products and systems that your diversification program is bringing on line, and what are some of the important success factors in the successful manageability of your new concepts and systems?

MR. MONTGOMERY: So far we have done this in-house and by the management people just working extra hard. We have created five different organizations, each with its own board and management staff. All this has been held together by a loosely coordinated informal system of interlocking trustees and myself going from one board to the next, trying to manage the thing. This is actually why Tribrook is in working and has been for the last 14 months. We are developing a new organizational structure, and I think that Sherwin Memel will be getting into some of this later in the program.

You have to develop a board structure, a management structure to coordinate these organizations. My own job is going to be quite a bit different. I'm already starting to think of what kind of performance standards I'm going to have to develop so I can track, on an ongoing basis, the operation of the hospital. I will not even be in the hospital any more; I'm going to be away from the hospital in a different office building complex. At any rate, you must keep building your management structure as you go along, and that's where we are at the moment. Doctors used to look at me as the guy who knew everything that was going on in the hospital, and now I don't even know what some of the problems are. But I know the administrator I have there and he knows those problems, I meet with him every week and I'm making sure that we are on top of the problems, but it takes restructuring.

MEMBER: You have other hospitals in your nine-county area; what are your relationships with them?

MR. MONTGOMERY: We handle things on an up-front basis; we're perfectly clear about what our intent is. We work on a highly professional basis. That does not mean we do not disagree. But we have never testified against another hospital in a CON hearing. We are cooperative with them in terms of providing information, but if we can package a program better or make a better deal to produce a better product, we will do it.

RICHARD JOHNSON: Would you describe your hospital board to the group?

MR. MONTGOMERY: The hospital board has seventeen members, five of whom are physicians. They are

there by virtue of their officership on the medical staff executive committee; they are on the board for a total of four years. In our particular situation, the majority of the voting members of the corporation are from the active medical staff, so we have a very strong, medically oriented, physician oriented organization. Some people would see this as a detriment; I see it as one devil of a fine asset. Physicians are business people: They are running small businesses, they know marketing, they are detailed all the time. If you deal with them in a business-like way and inform them of what you're doing so they see it's being done for the benefit of their patients and not just to increase the bureaucracy, they like that because they know that your product is going to be of value to them. So our physician component is a real asset in our case.

The other members of the board, other than myself, are people with business and legal backgrounds, the normal kind of trustee background, and we work very carefully in selecting good trustees.

MEMBER: Bob, you indicated that your program managers have the liberty of sharpening the price of one of the products of these programs. How and when do you test the impact of that sharpening on your finances?

MR. MONTGOMERY: When they do these things, they build in a period for reevaluation, and it is the finance man's responsibility to make sure that it's working. The department head discovers he has a problem on the pricing side of the product; he discusses with the assistant whether to modify this. If they want to do that, they can do it. They work on this with the finance man, who knows they're changing the rate structure. They build in a review factor to take a look at it in three months and see what the result has been.

MEMBER: So your review is after the fact rather than in the form of projections?

MR. MONTGOMERY: Yes, we just do not have the staff to do price sensitivity in the market, other than when we are starting a new program and need to look at the competition and the price. We determine what we think our costs are and how close we can come to the price, and sometimes we decide we cannot compete. The other guy has got a better mousetrap, so to speak, and so we back off — unless that service is one that is going to feed other services that are necessary to round out a program, then we might take it on.

MEMBER: One of the problems in developing new programs and new interest in the community hospitals is the physician's fear of the hospital administration

getting into the practice of medicine. What has been the reaction of your hospital over the years in developing your program, and how have you involved the medical staff leadership in the planning process?

MR. MONTGOMERY: We have physicians so involved, it is amazing. The number of committees we go through is just horrendous; it is a very prolonged planning process with about twenty steps. But it takes that kind of time and involvement to educate physicians. You're not going to beat them, but you can educate them, bring them along, show them the problem and your solution — and the tricky thing is showing them how the solution is going to help them, where it is going to be to their benefit.

At first, when we started talking about a sports medicine clinic, all the orthopedists were concerned. When I showed them how many hundreds of visits this meant a month to the sports medicine clinic, what percentage of the sports medicine clinic procedures would require follow-up visits, and how many of the people who would use the clinic did not already have a physician, their eyes lit up because they saw the clinic meant more work for them and work means money. After all, they are in business.

MEMBER: You mentioned having a pricing system; I think you said you had a five-tier system. How do you handle that considering all the governmental groups and so forth? How can you justify having five different prices for service?

MR. MONTGOMERY: Well, in most of our acute hospital services, we have a three-tier system. If we provide the service on an inpatient basis, it's our standard rate. If it's an outpatient basis, we price it according to what we think the differentiation is in the cost, and we are prepared to document that. When we get to laboratories, that requires competing on the commercial side of it. We have had to set up a separate organization as part of our ambulatory health service organization, where we're linking sports medicine, home care, hospice, and the commercial lab. Eventually we will be in the equipment rental business and a number of other things.

In that system we can go to three other pricing systems, depending on whether the physician bills for the service or we bill, whether the physician draws a sample or we have the franchise on the drawing station in that particular medical office building. So we gear it to our unused capacity.

Governance and Ownership and Vertical Health Systems

SHERWIN L. MEMEL

The second session of the Twenty-second Annual George Bugbee Symposium on Hospital Affairs convened at 1:30 P.M. with Reed Morton presiding as chairman.

CHAIRMAN REED MORTON: I am Reed Morton, lecturer and assistant professor in the Graduate Program in Hospital Administration. I have had the opportunity throughout this quarter to work with George Bugbee in the students' case studies of hospitals; this is a chance to see such work at the major league level.

Our next all-star is Sherwin L. Memel, senior partner with Memel, Jacobs, Pierno and Gersh in Los Angeles, which has an extensive commitment to the health care field.

SHERWIN L. MEMEL: To begin with, I would like to clarify some points. Because of time constraints, today we are dealing only with not-for-profit systems, although much of what I say will be applicable to the investor-owned systems. Also for the sake of brevity, we must make some assumptions or accept certain premises.

Our first assumption is that hospitals face serious, continuing, and accelerating pressures for change. I am not going to detail those. Second, hospitals cannot survive if they exhaust all of their energies and resources merely reacting to and fighting these pressures; rather, they must act, must adapt and stay one step ahead, particularly with regard to proposed government regulation. Third, hospitals in large measure are very late in making the necessary adaptations, and they are unfamiliar with many of the business tools available to the nonprofit sector and the investor-owned sector. Fourth, those who adapt will be the survivors. Finally, it is *possible* to adapt and to survive in today's environment.

For purposes of this discussion, I define *horizontal health system* as, generally, hospitals getting together, since we are talking about hospitals today. It could be nursing homes getting together, but what makes a system horizontal is a multiplicity of units of the same thing operating on the same level, whereas a *vertical system* is made up of different levels or types of care: You might have a hospital, a nursing home, an ambula-

tory care clinic, and so forth in a vertical structure. Obviously, it is possible to combine the vertical and horizontal arrangements in one system.

It is important to note that we are talking about arrangements of *institutions*, not of *buildings*. Moreover, vertical and horizontal health systems include institutions within one geographical area or outside of that area, so that the systems we discuss exist in very broad, dispersed geographical areas as well as narrow, compact areas.

I. INTRODUCTION

As far as the literature and research on this subject are concerned, vertical health systems are much fewer in number and more difficult to put together than the horizontal systems are. They have yet to emerge in the way that we believe governmental pressure is going to force them to emerge, particularly when the HSAs are operating full force.

Vertical health systems can come into existence in a number of ways. First, they can have their source in internal development. A given institution can develop the capacity to render additional levels of care; these may be provided within the same institution, for example, progressive care divisions or wings. Second, vertical health systems can develop by acquisition. A given institution can acquire a second institution which would be delivering either a "lower" level of care (e.g., nursing home) or a "higher" level. Third, a vertical health system can arise as a result of merger of two or more institutions rendering different levels of care. In addition, such a system can come from the creation of a consortium or joint venture in the form of a partnership, a corporation, or some contractual arrangement. Finally, an informal arrangement can produce a vertical health system, so that the people just work together as a matter of practice without any type of commitment among themselves to a long-term, formal relationship.

The way that a vertical health system comes into existence will condition the form of governance and the ownership of the system.

When all the components of a system are owned, directly or indirectly, by the same entity or control group, there are greater opportunities for developing

corporate structures that deal effectively with the regulatory environment. However, when the system is a consortium, joint venture, or other "non-owned," informal type, interinstitutional politics will impose significant limits on the system's operation.

Next I consider the various models of vertical health systems: the single-corporation, the subsidiary, the parent, and the consortium models. For each I will describe the typical legal structure, some fact situations, and the advantages and limitations of the structure.

II. CORPORATE MODEL FOR THE VERTICAL HEALTH SYSTEM

Figure 1 describes the single corporation; this is typical of what you will find around today. Note that in the figure, the formal, legal structures of organization are described by rectangles, while the informal, unincorporated divisions are in circles. Legally, this is a single, nonprofit corporation, exempt from federal and state income taxes.

There are several facts to be noted about this corporation model. Generally, the various levels of care are organized as unincorporated divisions. Technically speaking, if somebody were to sue the clinic, they would really be suing the hospital. The hospital has all the

liability for the clinic, nursing home, or hospice because they are all in a single corporate entity.

The corporation engages in activities which are not reimbursable under most cost-reimbursement programs; such activities include medical office buildings, pure-research facilities, residential care facilities, some medical education programs, and hospice.

The corporation holds title to a mixture of high- and low-risk assets and activities. High-risk assets are those that are associated with the delivery of patient care and are therefore likely to give rise to malpractice claims and other types of liability exposure; the low-risk assets are those which can very easily and adequately be covered by minimal insurance, such as medical office buildings, endowment funds, classrooms, and residences.

Sales of service to third parties (physicians, other hospitals, businesses) are conducted directly by the hospital corporation. The hospital undertakes limited fund-development activities, often through a "development office" which is simply a department of the hospital for purposes of legal analysis. This office is for one-shot projects, not long-range programs. Typically the hospital is considering many new activities in

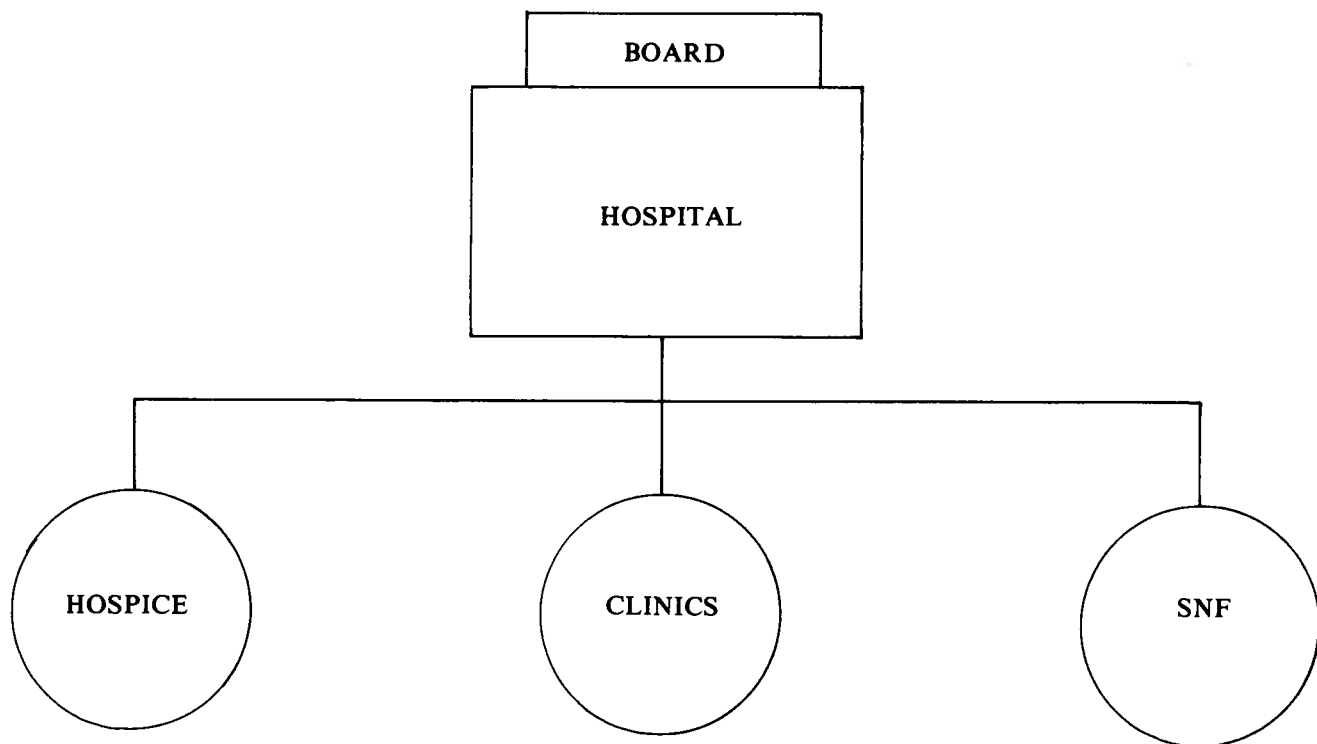


FIG. 1. — Single corporation model; ○ = division, □ = corporation

response to the pressures to which I referred at the outset, but its plans are often not well developed or sufficiently long term.

This brings us to this model's vulnerabilities or limitations. The single corporation is a very vulnerable kind of structure today because the combination of regulatory programs which affect hospitals will undermine the viability of existing and proposed activities. Let me indicate these problems in more detail.

One of the reimbursement problems here is overhead allocation. Medicare does not reimburse for the "direct" costs associated with the nonreimbursable activities, such as operating medical office buildings or pure-research facilities. In addition, Medicare rules call for a portion of the hospital's overhead (general and administrative expenses) to be allocated to such activities. In our experience, these overhead allocations have been disproportionately large and operate as a penalty on the system for engaging in nonreimbursable activity. Another reimbursement problem is investment income offsets: Medicare offsets certain forms of investment income against interest expense. This produces unnecessary losses for the system which can add up to hundreds of thousands of dollars.

Losses also result from the treatment of gifts and grants, not only under reimbursement programs but under rate-setting programs as well. Gifts which are deemed restricted to operations of a particular department are offset against the costs of that department for the year in which the gift is received.

Problems similar to those created by reimbursement arise under cost-containment legislation and state rate-setting programs. However, the problems are more serious here because they affect all charges imposed by a health facility, not just the cost-reimbursed portion of the patient population. In addition to reimbursement and rate-setting vulnerabilities, the single corporation model has definite limitations with regard to taxes. The problems in this area will probably get worse.

Recently the IRS shifted more than 150 agents out of employee benefit plan work and into the exempt organization area. The impact of this shift is being felt in California: The California Hospital Association reports more than fifty times as many audit inquiry letters have been received in 1979 as in 1978. The IRS has also instituted a "large case program" calling for regular audits of hospitals with more than \$10 million in assets. This increase in manpower and focus necessitates

greater care in order to avoid unrelated business income tax and even possible loss of exempt status.

The fourth area of vulnerability concerns certificate of need. Most states now have CON laws which arguably require hospitals to obtain a CON for any capital expenditure "by" a health facility. Under current law in California, a hospital may not be able to proceed with any capital expenditure involving more than the financial threshold without going through a CON proceeding. This is true even though the capital expenditure has nothing at all to do with patient care, for example, a residential care facility, a medical office building, or a commercial office building.

Finally, the system organized as a single corporation has enormous liability exposure. As malpractice judgments grow in size and as more hospitals elect to self-insure, many boards of trustees are becoming concerned about finding ways to better protect hospital assets from catastrophic recoveries in excess of insurance protection.

III. SUBSIDIARY MODEL FOR THE VERTICAL HEALTH SYSTEM

If you look at the structure of the subsidiary model (fig. 2), you see all rectangles, which means that the hospital, the hospice, the clinics, and the SNF are all separate nonprofit corporations, exempt from federal and state tax. All the subsidiaries are controlled by the hospital through its power to appoint and remove board members. The subsidiaries generally qualify as public foundations under section 509(a)(3) of the Internal Revenue Code, that is, they are controlled "support" organizations. The element of control virtually automatically gives them the exemption from private foundation status which was created in the 1969 Internal Revenue Code. The private foundation status is a very undesirable status; it has great insecurities for donors making contributions. It has very stringent conflict-of-interest provisions and involves much paper work and complexity that you want to avoid. It is better to have a public foundation status for each nonprofit corporation involved in your horizontal or vertical system; one way of getting it is by control. But control has other problems, which we will get to below.

As for its typical features, this system engages in a variety of activities identical to those in the single corporation: the selling of services by the hospital corporation, limited fund-development programs, and

so forth. However, this model's vulnerabilities differ. It has a little less vulnerability from the CON standpoint because the subsidiaries are separately incorporated organizations, and one can argue that if a hospice, for example, builds a facility, this is not within the definition of the CON law, because the hospice is not a place where patients come for acute care. However, the subsidiaries are controlled by a health facility, the hospital, and therefore they may not be in a better position to proceed with capital projects without a CON.

Reimbursement is a complex issue for the subsidiary type of vertical health system. In the first place, the accounting rules affecting controlled subsidiaries have been very confused. The Hospital Audit Guide presently calls for combined financial reporting for related organizations if "significant resources or operations of a hospital are handled by such organization ... and

they ... are under the control of (or common control with) ..." the hospital. That language is very confusing, and there has been little consistency of accounting treatment under the existing guides. According to the American Institute of Certified Public Accountants (AICPA), "The guide does not give sufficient guidance about or explanation of what constitutes 'control' or 'hospital resources.' As a consequence, a variety of reporting practices are being followed and the financial statements of some related organizations are combined with those of hospitals, while the financial statements of other organizations in similar circumstances are not. The related facts and circumstances are sometimes disclosed and sometimes not disclosed."¹ The AICPA's proposed "statement of position" claims to clarify the

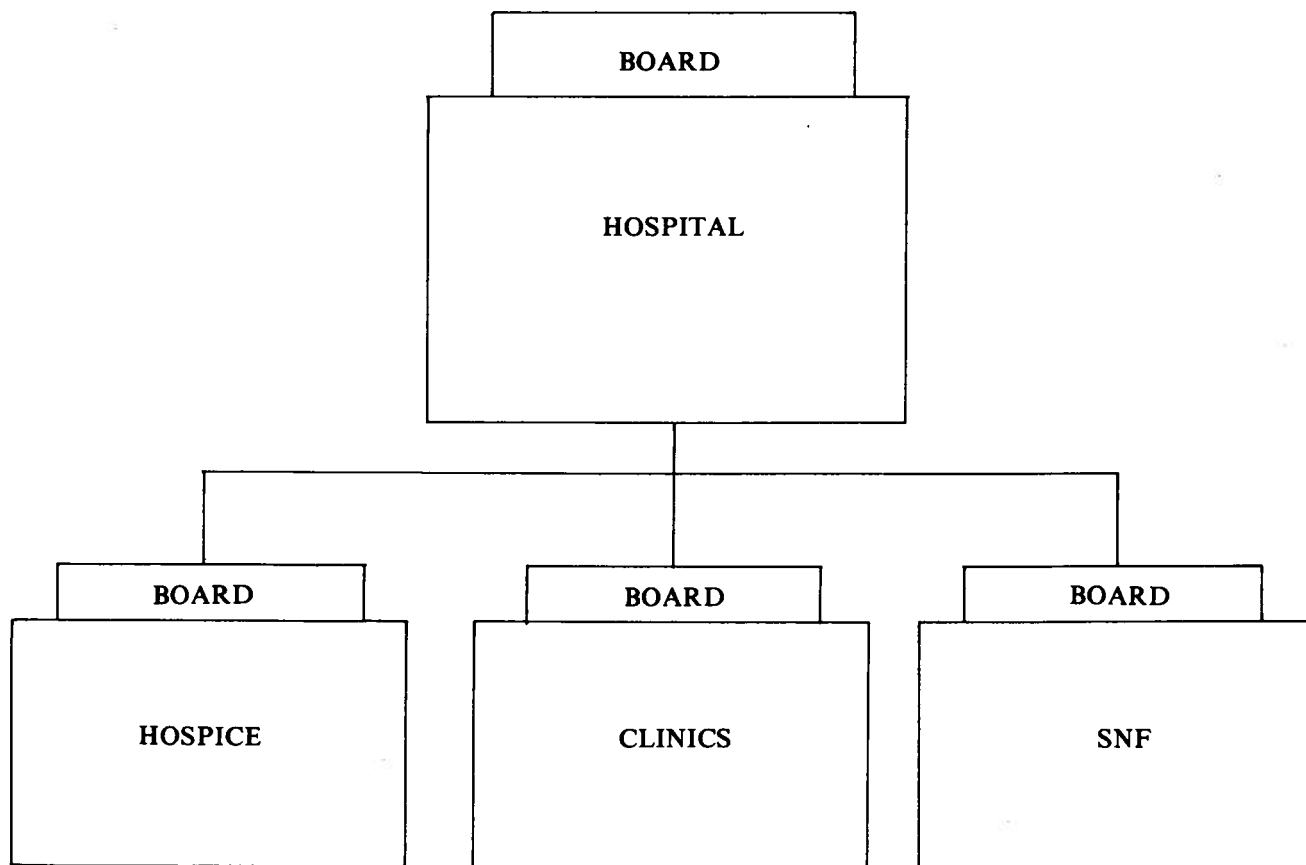


FIG. 2 — Subsidiary model

¹AICPA, Subcommittee Matters, "Statement of Position of Clarification of Reporting Practices concerning Hospital Related Organizations" (exposure draft, AICPA, New York, August 31, 1979).

existing situation. It calls for combined financial reporting of the assets and liabilities of a subsidiary where the hospital has “the ability to direct the management and policies of the foundation despite not having a majority voting interest . . .” and where the hospital “will be, for all practical purposes, the sole beneficiary of the related organization’s activities.”²

What are the consequences of consolidation in the subsidiary system? Consolidation for financial reporting purposes may lead to consolidation for regulatory purposes as well. Medicare regulations now provide for application of generally accepted accounting principles. However, comparable attitudes may develop in the CON area or among rate-setting agencies if an attempt is made to use controlled subsidiaries as a base from which to conduct new activities that would be regulated if done directly by the hospitals.

Another limitation of this system stems from the related-organization principle. Since the subsidiaries are controlled by the hospital, any new programs calling for a sale of services by the subsidiaries to the hospital will be covered by this principle, which means that the hospital will be reimbursed only for the *costs* to the subsidiaries of providing such services, not the *charges*, even though those charges are as low as or lower than elsewhere in the community.

A final word about controlled subsidiaries. Although they have existed for many years in the hospital industry, it is extremely doubtful whether they will provide a solution to the regulatory pressures described above. The threat of consolidation for financial reporting and regulatory treatment is so great with respect to these organizations that we would encourage consideration of the alternatives discussed below.

IV. PARENT MODEL FOR THE VERTICAL HEALTH SYSTEM

The parent model is often called the “holding company” model. The use of this type of organization has been widespread in other highly regulated industries, especially in banking and utilities. The key concept upon which the parent corporation approach rests is that, generally speaking, assets and revenues of the parent are not reflected on the financial statements of its subsidiaries and assets and revenues of the subsidiaries are not combined with one another. This raises the possibilities that (1) the parent can engage in many activities which would be regulated if conducted directly

by a subsidiary, (2) the subsidiaries can operate with a minimum amount of regulation, and (3) additional subsidiaries can be created that will be subject to little or no health regulation at all.

Figure 3 is a diagram of the legal structure of the parent model. First let me point out some features of this model as a corporation. The parent is organized as a nonprofit corporation. Subsidiaries may be nonprofit corporations, but this is not necessary; the whole system can be a mixture of for-profit and not-for-profit activities. However, for sake of simplicity, I will be discussing the case in which all institutions in the system are nonprofit. These corporations need not incorporate in any specific state. The advantages and disadvantages of incorporating the parent into one state or another are so mixed that our position thus far has been that, unlike bank holding companies, which like to incorporate in either Delaware or Nevada, the system might as well incorporate in its own state.

There are several noteworthy aspects of corporate “membership” in this model. The parent will become the sole member of the existing hospital corporation and each subsidiary. This will give the parent the power to appoint and remove board members of the subsidiary at will. Where the existing corporations have numerous public members there may be difficulty. Some state laws permit transfer or even termination of memberships. Where possible, consider transferring memberships in the subsidiary to memberships in the new parent. Properly understood, this should eliminate opposition. However, some attorneys are recommending eliminating public memberships where possible. For example, under the new California nonprofit corporations code, members can bring derivative suits.

Now mind you, the old AICPA definition, as well as the new one, says that where the hospital has control, there is a guaranteed consolidation, but the control here runs from the parent to the hospital (and other organizations), not from the hospital to the parent. Note that in figure 3, there is no line between the hospital and the other organizations, as there is in the single corporation and subsidiary models, and that is important.

The purposes clauses in your parent and other organizations are extremely important, the most important provisions in the articles of incorporation, because they tell you what you can and cannot do. The nonprofit corporation under the laws of almost every state holds the assets in a “charitable trust” as a fiduciary for the general public. The purposes clauses define the terms of

²Ibid.

this trust and may lock the parent into particular activities.³

On a tax basis, this system should apply for federal and state income tax exemptions and public foundation status. Here you want to avoid a problem that was a benefit under 509(a)(3). An institution has a public foundation status as a controlled subsidiary of a hospital under 509(a)(3) because it is controlled by the hospital. Under the parent model, rather than hospital control, you want the parent to have control; thus you want to go under another section of the Internal Revenue Code, 509(a)(1), and the section 170(b)(1)(a)(vi) regulation, that allows the institution public foundation status if it can meet a public support test. However, there are a number of problems with this, particularly those involving the definition of "support" and the possibilities for fund raising. For example, if the parent board is to be identical with the board of the subsidiary, the new structure will not be able to bring in new faces to be responsible for fund raising. However, some organizations have had success using "advisory" boards to perform this function. If the parent's activities generate the "wrong" kind of income, the parent may be unable

to meet either of the public support tests. If a foundation exists, or is planned, a concerted fund raising effort by the parent would be counterproductive. It may be possible to use hospital or foundation grants to the parent to meet the public support test.

Despite the historical role of section 509(a)(3) (assuring public foundation status for organizations controlled by a hospital), it may be possible to qualify the parent as a public foundation under this section. We are in the process of applying for a national office ruling which would take this approach. If this could be achieved, the parent would not have to raise any money from the public to be a public foundation at the parent level. Earlier, under the single-corporation model, I mentioned the problems of having both low-risk and high-risk assets and activities within one corporation. The parent model offers other possibilities. Many hospitals have assets which might well be transferred to a parent, for example, endowment assets, medical office buildings, parking lots, education and research facilities. Such a transfer could avoid a number of problems;

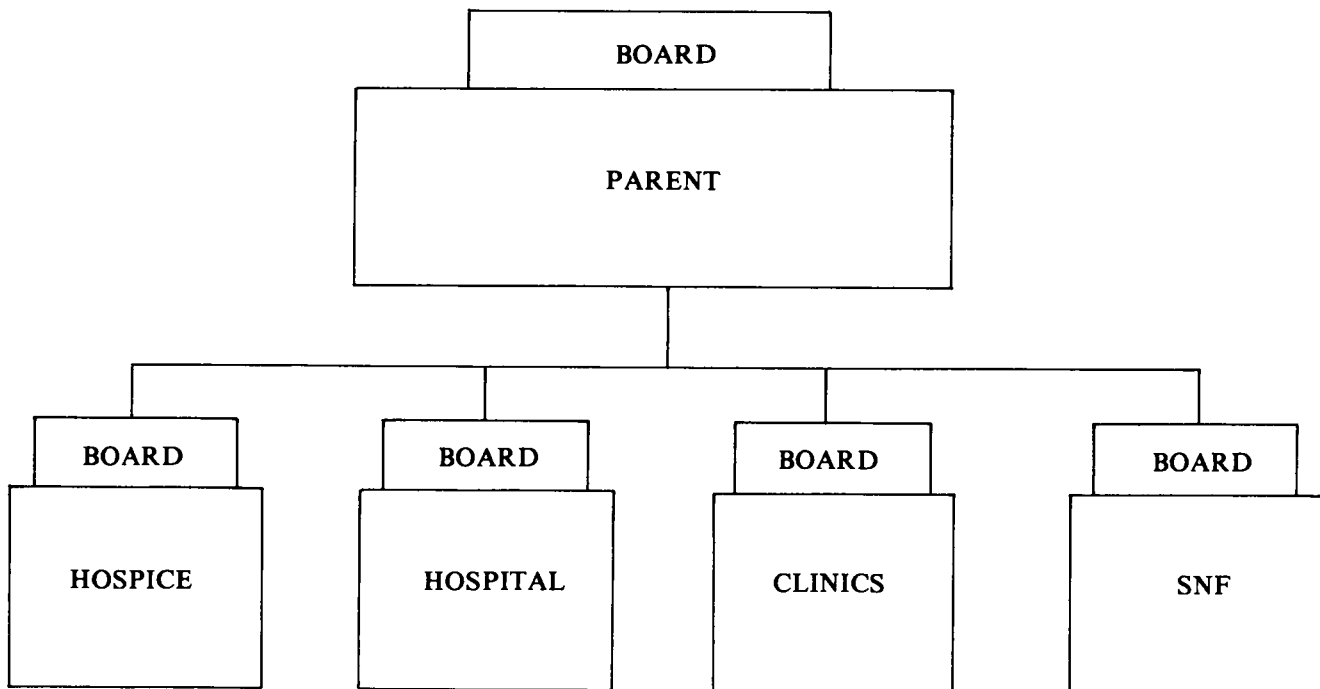


FIG. 3 — Parent model

³For a case in California in which the hospital's actions were restricted as a result of the attorney general's interpretation of the language in the corporation's purposes clause, see *Queen of Angels Hospital v. Younger*, 66 Cal. App. 3d 359 (1977).

however, there are many legal questions which must be resolved before such action can be taken:

- (1) Do restrictions in bond indentures and loan agreements preclude transfer? Can waivers be obtained?
- (2) What will be the impact of a proposed transfer on the "support" of the parent under section 170(b)(1)(a)(vi) of the IRS Code?
- (3) Do gift restrictions limit the hospitals' ability to make transfers?
- (4) What is the property tax impact?
- (5) Will the transfer result in additional amounts of unrelated business income tax? In other words, some activities which are "related" to the charitable purposes of the hospital subsidiary may not be "related" to the purposes of the parent. Basically what that means is, a nonprofit organization which engages in certain nonexempt activities may still be able to hold onto its tax-exempt status but, nevertheless, will have to pay conventional income taxes on income from those activities. Many hospitals have been involved in unrelated business income taxable activities for a number of years, do not realize that, and may end up with a very nice retroactive assessment bill after a visit from the auditors. So this is an important question to consider.
- (6) Will the transfer result in a breach of charitable trust or fiduciary duty?⁴

The parent model enables certain new activities, such as the sale of management and other services. It is possible to move certain employees out of the hospital and into the parent with a view to selling their services to others as well as back to the hospital. This step might permit payment of increased compensation and benefits to key employees, while it simultaneously provides valuable management resources to others and reduces the subsidiaries' net cost.

In this model, as in the others, there are reimbursement-related problems, but they are very minimal here. Under the related-organization principle, since the parent controls the subsidiary, Medicare (and other cost-reimbursement payors) will only pay the subsidiary an amount equal to the parent's cost of providing services. Sales to third parties by the parent may also reduce the reimbursable cost to the hospital subsidiary. Thus, if the parent corporation renders any services to the hospital,

⁴E.g., *Denckla v. Independence Foundation*, 193 A. 2d 538 (Del., 1963).

it is going to be a wash on a reimbursement report. The parent will not be able to get charges. The hospital will only be allowed to get reimbursement costs. However, that one disadvantage is minimal compared with all the other advantages I have mentioned.

I will just mention some items related to taxes to keep in mind with regard to the parent model. (1) Unrelated business income tax (UBIT): Net income generated by sales to third parties probably will be taxable at ordinary corporate rates.⁵ (2) Impact on parent's public foundation status: To meet the "support" tests specified in IRC section 170b(1)(a)(vi), the parent must increase its fund development production if UBIT increases.

Accounting issues include consolidated financial statements and separate statements for subsidiaries:

Consolidated financial statements. — "Consolidated financial statements present the financial position and results of operations of a parent company and its subsidiaries, essentially as if the group were a single enterprise comprised of branches or divisions. The resulting accounting entity is an economic rather than a legal unit, and its financial statements are considered to reflect the substance of the combined economic relationship to an extent not possible by merely providing the separate financial statements of the corporate entities comprising the group."⁶

Separate statements for subsidiaries. — "... separate statements or combined statements would be preferable for a subsidiary or a group of subsidiaries if presentation of financial information concerning the particular activities of such subsidiaries would be more informative to the shareholders and creditors of the parent company than would the inclusion of such subsidiaries in the consolidation. For example, separate statements may be required for a subsidiary which is a bank or an insurance company and may be preferable for a finance company where the parent and the other subsidiaries are engaged in manufacturing operations."⁷

V. CONSORTIUM MODEL FOR THE VERTICAL HEALTH SYSTEM

The models discussed above assume ownership of all entities in the vertical health system by a single institu-

⁵Cf. Rev. Rul. 69-633, 1969-2 C.B. 121; *Metropolitan Detroit Area Hospital Service, Inc.*, 445 F. Supp. 857 (E.D. Mich., 1978).

⁶Accounting Principles Board no. 4, 3 *AICPA Professional Standards*, sec. 1027.23, at 7309 (Chicago: Commerce Clearing House, 1977).

⁷Accounting Research Bulletin no. 51, 3 *AICPA Professional Standards*, sec. 2051.04 at 8182 (Chicago: Commerce Clearing House, 1977).

tion. The consortium model assumes, on the contrary, that the entities in the system are separately owned but have associated together to achieve specific, limited objectives. The nature of the consortium will vary with the nature of its activities. The consortium may involve little more than shared services or as much as joint financing, planning, and budgeting. As figure 4 shows, the system is made up of separately incorporated bodies, with the consortium instead of the parent. The dotted lines, rather than solid lines, indicate that there are only informal arrangements, contractual or some other arrangement, between the consortium and the other organizations.

The consortium can take a number of forms, including the general partnership, the nonprofit corporation, and the unincorporated association. For example, four hospitals may get together, or a hospital, a hospice, a clinic, and a skilled nursing facility may do so. They agree to have a committee that is going to be the consortium and run things on an informal or a letter-agreement basis. Nevertheless, for public law purposes, for liability purposes, they are considered an unincorporated association.

There are pitfalls in people dealing together in this way, and there are some very large entities operating in the consortium format today which have ignored the

significant exposure problems, from both the liability and tax aspects. Care must be taken to avoid tax on revenues of the consortium when a corporate form is used. Certainly 501(e), shared-services status, will not be allowed for a normal consortium.

Control over the consortium can be shared in a number of ways, depending on the legal form of the consortium. If the consortium has the form of a general partnership, control can be by partnership agreement. If it is a nonprofit corporation, control is by memberships and board positions. Finally, an unincorporated association is controlled by bylaws and contract.

A resource to consult on the subject of consortiums is *Multi-institutional Hospital Systems*, published by the Hospital Research and Educational Trust and the Kellogg Foundation in 1979.⁸ The book includes ten case studies. It discusses, for example, the Virginia Mason Health Services Consortium, which is described as a professional and administrative support, urban-rural services consortium. It is based on the notion of a consortium as a group of institutions in an area, voluntarily joined to achieve specific purposes. Central to the concept is the lack of a requirement that participating institutions hold *all* major goals in common; rather,

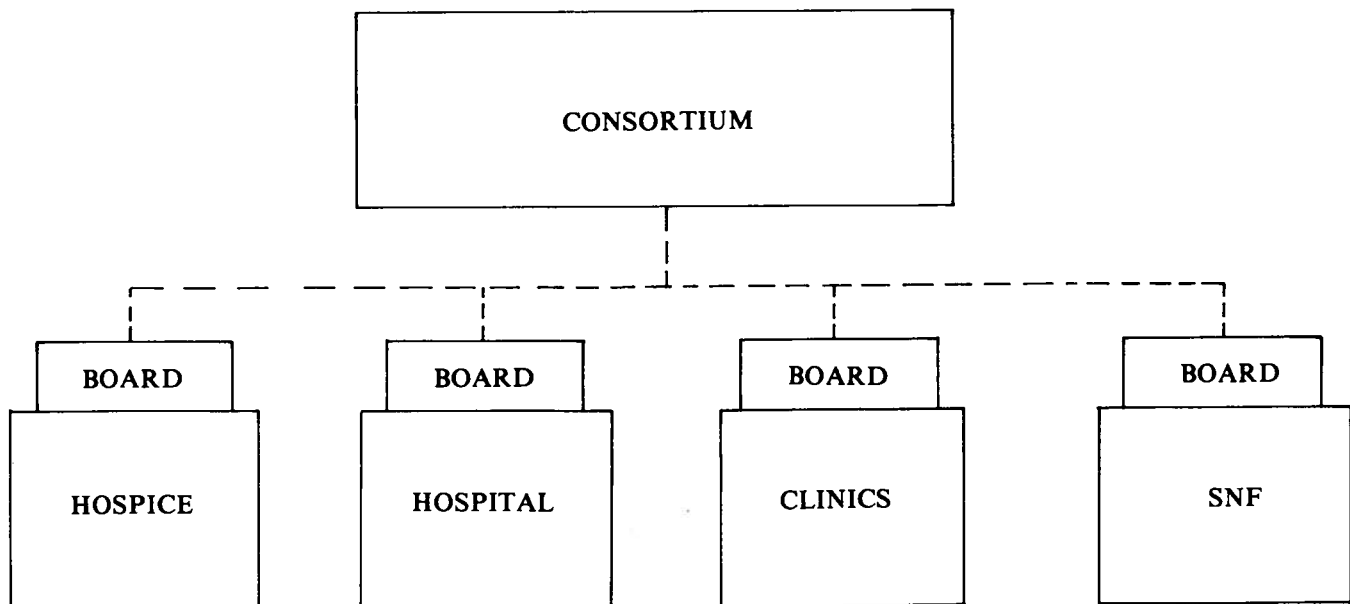


FIG. 4 — Consortium model

⁸ *Multi-institutional Hospital Systems* (Chicago: Hospital Research and Educational Trust; Battle Creek, Mich.: W. K. Kellogg Foundation, 1979).

advantages are found in pursuing specific goals which the institutions do have in common. I think it is important to note what the book has to say about trustees and the critical importance of the governance function in the performance of multiinstitutional health systems:

As systems continue to evolve, it is argued that trustees will have to focus on long-range planning and strategic decision making while moving away from involvement in institutional operations. The governance role in these emerging organizations requires individuals who can work as part and think in terms of systems. Trustees will be charged to make difficult resource allocation decisions, attempting to balance the need of the system with those of the individual facilities. Trustees at the corporate level are encour-

aged to think in terms of the greatest good for the entire system. At the local level trustees seek to protect their hospitals for their communities, while they attempt to view their facilities within the context of a network of institutions.⁹

It is a cultural shock for many trustees to move into these areas. In the long term, it may be necessary to recruit new trustees or train or retrain the trustees you have.

There are many more topics we could consider, but here I just wanted to describe the different forms available for vertical health systems (which also adapt to the horizontal system or a combination of the two), some legal facts about these forms, and the benefits and problems inherent in each form.

⁹Ibid., p. 40.

General Discussion

REED MORTON, CHAIRMAN

RICHARD JOHNSON: Sherwin, if you have the parent as a for-profit and the hospital as a non-profit organization and you want to transfer the parking lots and those kinds of things to it, can you?

SHERWIN MEMEL: No. If you are talking about doing it by way of gift, if you want to sell it for fair market value, you can do it. Typically, the parent does not have any money. In an individual situation perhaps somebody could demonstrate to me the benefit of a for-profit parent, and I am not saying there could never be benefits, but typically, I think it is most advantageous to have a not-for-profit parent if you are talking about a not-for-profit system.

RICHARD BATT: Is it possible to layer parent corporations so that you might have one parent corporation that is involved nationally, and in the local area the subsidiary parent has a vertical health system?

MR. MEMEL: This is very common, and you would call it a "regionalization" concept. You could also do that within a state, if it is a large state: You could have one state parent and then you could have separate parents.

All this depends on the purposes to be accomplished. A lot of that, I think, has to do with the politics, giving people representation and handling the trustees of these institutions in a specific area. Or perhaps you have different shared services concerned in different geographic areas. So there are a lot of reasons why you may have a system where you might interpose other parents. You might call this a regional corporation with several parents, and one parent over the regional corporation.

TIM SIZE: What antitrust considerations should we have with these various models?

MR. MEMEL: As I indicated, there are many other considerations. I refer you to a book by my partner Martin Thompson, published late in 1979 by Aspen Systems, on antitrust in the health care field, and that will give you some good answers to your question and many of the other questions raised today.

But the Federal Trade Commission and the Department of Justice have not resolved their positions on this. They have not automatically accepted HEW's position that planning justifies anything. The recent decision which said that the antitrust laws do not apply to all CON matters (at least, insofar as the facts of that case

were concerned) is on appeal. It is only in one jurisdiction; it is not binding law.

It is clear from the Rex Hospital case that federal antitrust laws apply to hospitals on very little grounds other than having income in interstate commerce from normal hospital operations, so if you are going to monopolize or consolidate in an area, there are serious antitrust implications, and there are a new set of merger regulations. You have to notify people when mergers are going to take place between organizations of certain sizes, and then the Justice Department has an opportunity to comment. That is a major consideration when you are getting together and doing this kind of thing. In my judgment, there is less of a problem when you are doing the vertical type of integration than in horizontal type because you are addressing yourself to different segments of the market.

ROBERT MONTGOMERY: Sherwin, in the consortium law, if you are going out on capital financing, can any of the individual elements or organizations pledge their assets or be used as collateral for, say, financing one or the other elements?

MR. MEMEL: That is very difficult because in the typical consortium there is no ownership and no control, whereas in all the other models there was control in some form.

We have dealt with most of the major investment banking houses. All of them, believe it or not, love this: They love all of the organizational configurations because they see this diversity as a long-range benefit, a plus to the solvency of those institutions and the guarantee of their loans.

This is a new field. In the last three-and-a-half or four years in which so many of these new concepts have emerged throughout the United States, board members, accountants, and legal counsels have been concerned about numerous potential problems. And 99 percent of those problems, those horrors they feared, have not been major problems. One of the problems that was constantly raised was, "The investment bankers are not going to stand for it, they will not like it. They will not let us do this under the indentures and so forth." Yet we have worked this out, with cross-guarantees and all sorts of things. However, when you have a consortium, that tool is taken away from you because there has got

to be a bona fide purpose. You can lose your tax exemption by giving away money improperly.

So I am not saying that it cannot be done in the right set of circumstances. If you were talking about building

a shared-services facility, a laundry, and you were fortunate enough to get an exempt status for it, and they were all going to kick in money or guarantee part of the money, that would probably be legitimate.

Financing and Vertical Health Systems

DONALD R. ODER

CHAIRMAN REED MORTON: Our next speaker is Don Oder, senior vice-president at Rush-Presbyterian-St. Luke's Medical Center, which is a local example of a vertically integrated system. Don is also a member of the Illinois Health Financing Authority and, perhaps not least of all, a member of the second-year class in the Executive Program.

DONALD R. ODER: Thank you, Reed; it is good of you to let a student participate in your symposium this year.

National health planning legislation and regulations include six performance factors to be considered in determining the appropriateness of a hospital service: availability, accessibility, acceptability, continuity, cost, and quality. Recent efforts at the Health Care Financing Administration have clearly emphasized *cost* as its primary consideration. The very real possibility that the responsibility for health care planning will be transferred to that agency should cause us concern for the future of the hospital industry. Although cost control is not the primary rationale for a vertical health care system, the effect on costs is a consideration in every action we take.

At this time a completely integrated vertical health care system is more a theory than a reality. Most hospitals offer some degree of vertical integration in the levels of inpatient and ambulatory care. The completely integrated system would include the full range of personal health services required by a given population, offered in a coordinated manner.¹ The integration of the educational programs in the health professions would complete the system.

A vertical system can be developed through cooperative arrangements with various health care providers and educational programs. It is not necessary to have all units under a single management; however, the problems of organizing a system of multiple autonomous institutions limit the potential benefits. Systems built on affiliations have many virtues, but financial advantage tends not to

be among them. Cooperative arrangements among autonomous hospitals in a vertical system relate more to continuity and quality of care than to operating efficiencies.

The conventional shared services for administrative and other support services are equally applicable to both vertical and horizontal systems. These types of shared services are popular, and it is important to take advantage of such a consolidation of services which offers significant economies of scale. However, this has little to do with the presence or absence of a health care system. It may be more advantageous to have some of these services provided by a hospital association or council rather than by the system. The important consideration is that the administrative and support services be provided by the most efficient and convenient service available. There is no magic to these services being provided inside or outside the system. Shared support services have no relationship to a vertical system; shared support services relate to prudent buying. The sharing of such services does not constitute a health care system.

Doctor Charles Sanders, director of the Massachusetts General Hospital, referred to the system at Rush-Presbyterian-St. Luke's Medical Center as an example of the corporation model.² He described this model as the merger of a network of hospitals into a single corporation in which the medical center exerts major control over the members. This model thus involves the transfer of authority to the central corporation, with significantly reduced autonomy for the participants. Doctor Sanders was referring to only a portion of the Rush system that is owned or controlled by the medical center corporation. This would constitute the main hospital, geriatric hospital, branch hospital, HMO, home health nursing, and health professions university. The network hospitals that are associated and affiliated with Rush are completely autonomous. The agreements provide the framework for a good working relationship but specifically maintain the autonomy of each corporation.

In a case study of the University of Chicago Medical Center, Doctor Alvin Tarlov and his associates discussed the many problems of organizing a system involving a

¹Robin E. MacStravic, "Vertical Integration in Multihospital Systems," in *Multihospital Arrangements: Public Policy Implications*, ed. Scott A. Mason (Chicago: American Hospital Association, 1979).

²Charles A. Sanders and Kay W. Bender, "Point of View: Multi-institutional Arrangements in a Teaching Hospital Setting," *Health Care Management Review* (Spring 1980), pp. 25-33.

university center and multiple community hospitals.³ The carefully guarded autonomy of an affiliated hospital and the lack of commitment of the medical center to another hospital that it neither owns nor controls make program development slow and unpredictable. It is unlikely that a fully integrated vertical health care system can be built on the basis of affiliation agreements. Certainly there is not much to be said about the financial implications of a system based on the affiliation of various autonomous institutions. Although there may be certain specific programs developed between the medical center and individual affiliated institutions that provide a mutual financial advantage, a system of affiliated institutions has little general financial involvement. The direct financial cost of maintaining such a system tends to be undertaken by the medical center. Although it is difficult to identify all the costs at the medical center that are directly related to the building of a system, there are substantial costs, including the liaison office; coordinators in medicine, nursing, and administration; and continuing education. The future benefits are a matter of speculation because they are long term and unpredictable; the benefits may be described as casting bread on the waters.

In order to discuss the financial implications of a fully integrated vertical health care system, let us pretend that such a system can be established. In the Chicago metropolitan area it is theoretically possible to organize five to seven such systems—and to do so without antitrust problems, because there would not be a monopoly of all the facilities in the area.

THE MODEL SYSTEM

The possible extent of vertical integration for any industry is virtually limitless. The practical boundaries of the health care corporation should extend from the university education of health care professionals to the long-term health care facilities. In large metropolitan areas the system should not be geographically defined, so that patients, health care professionals, and students can have a choice of systems. The population to be served should provide the base for determining the extent of patient services and of manpower production.

For example, a comprehensive, vertically integrated care network serving 1 million people would include approximately 4,000 secondary-care beds, 600 general tertiary-care beds, and 8,500 long-term care beds.⁴ The

³Alvin R. Tarlov, Barry Schwartz, and Howard P. Greenwald, "University Center and Community Hospital: Problems in Integration," *Journal of Medical Education* (May 1979), pp. 370-78.

⁴Rush-Presbyterian-St. Luke's Medical Center, "Rationalizing the

total system would need to accommodate about 5 million outpatient visits, including solo and group practice, HMO offices, emergency rooms, neighborhood health centers, and clinics.

The system would provide appropriate levels of care consistent with the patients' needs, reflecting intensities of illness and complexity of diagnosis and therapy throughout the various health care institutions and staffs. The system should integrate academic functions and health functions in order to reinforce the positive impact of one on the other. The university hospital would be the referral center for the system.

The availability of such an organized system would provide many opportunities for economies of scale that cannot be provided by a single institution. The HMOs and home health nursing services need to have offices near the population being served but require a large volume in order to be financially viable. A branch office in the area of each system hospital would be ideal. A quality continuing-education program for physicians, nurses, and other health professionals can be self-supporting only with significant volumes. Other services, such as information systems and health care planning, would be unique to the system. The availability of consultations from medical specialists throughout the system would avoid many unnecessary referrals. In our utopian system the centralized or regionalized patient services would be located in the system without regard to the financial impact on an individual health care facility.

A balanced system implies the production of manpower in sufficient quantity to replace personnel turnover in the system. There would be no intent to have a closed system, but the import and export of manpower to and from the system should balance out. All patients receiving service within the system should share in the cost of education in the health professions.

Necessary services that are so highly specialized as to be uneconomical for a single system should be shared between systems. This intersystem cooperation, as well as the monopolistic implications of single-system areas, raises the question of competition or lack of competition.

COMPETITION

There has been considerable discussion of the public-utility nature of the hospital industry. The various regulations that control hospital facilities' additions and replacements, rates charged for services, and utilization of

Health Care System in Chicago," duplicated (Chicago: Rush-Presbyterian-St. Luke's Medical Center, March 21, 1980).

services taken as a whole are more all-encompassing than the regulations of many so-called regulated industries.

Competition among health care systems could be sustained in large metropolitan areas, but single-system health care in low-population areas would virtually be a monopoly with limited opportunity for competition. This situation is unavoidable but is not significantly different from the present single-hospital communities. Patients would still be free to travel outside the community for their health care services.

Whether hospitals are to operate in a regulated system or a competitive system has been the subject of much discussion in recent months. There are several legislative proposals designed to increase competition in the health care industry, but it is probably safe to say that government regulation of hospitals is here to stay. The proposed competition legislation tends to deal with the nature of health insurance coverage provided by employers and the promotion of HMOs as the most cost-effective system for health care delivery. Certainly HMOs provide an element of competition, as would any consolidation of the health insurer and the health provider. It is conceivable that a large vertical health care system could sell conventional health insurance that would provide financial incentives to select health services within the system. It would be necessary to establish considerable pricing flexibility before this could be a practical option.

How far hospitals can go in the organization of health care systems before antitrust questions arise is a matter for resolution by legal counsel.⁵ Even the actions of health systems agencies may have antitrust implications. The Justice Department recently warned the Central Virginia Health Systems Agency that competing hospitals risk antitrust violations if they meet at the request of a federally designated agency and agree to cut their services. The Federal Trade Commission (FTC) has had its problems with Congress but continues to be active in the health care industry. Even though not-for-profit corporations are exempt from FTC action, implications of restraint of trade in vertical integration should be considered.

REIMBURSEMENT

The current reimbursement system for health care services is not conducive to the efficient operation of a vertical system. The cost and payment methods of the

⁵R. A. Vraciu and H. S. Zuckerman, "Legal and Financial Constraints on the Development and Growth of Multiple Hospital Arrangements," *Health Care Management Review* (Winter 1979), pp. 39-47.

Medicare and Medicaid programs fragment the system and limit management flexibility in pricing services at the marginal cost.

A single institution may be three separate providers of service for Medicare and Medicaid, with separate provider numbers, cost limitations, and cost reports for acute hospitalization, skilled nursing facilities, and home health nursing. These services are an integral part of a vertical system but have to be treated as separate entities for cost-reimbursement purposes.

The cost limitation for routine services in the hospital and skilled nursing facility, home health nursing visits, and renal dialysis treatments divide the institution into isolated units for reimbursement purposes. Creative cost accounting among these cost-limitation areas, the other health care services, educational programs, and research activities becomes a way of life.

To the extent that a single Medicare/Medicaid provider number can be obtained to allow the consolidation of multiple institutions in a vertical system for cost-reimbursement purposes, there may be considerable advantage in the reimbursement of routine-service costs. The routine-service costs for reimbursement purposes are an average cost for all patients not in special care units. Any costs in excess of the federally established cost limitation are not reimbursed. The inclusion of secondary-care institutions in the average will dilute the higher costs at the medical center and lower the average routine-service costs for comparison with the cost limits. Examples of such single-provider institutions in the Chicago area are Presbyterian-St. Luke's Hospital and the Sheridan Road Pavilion, Evanston Hospital and Glenbrook Hospital, and Chicago Osteopathic Hospitals in Chicago and Olympia Fields.

There is a potential that state rate-review systems will eliminate the present conglomeration of cost-based systems utilized by various third parties, primarily government agencies and Blue Cross. There is no doubt a price to pay for such a regulatory system, and this is likely to be a limitation on total revenue available to each hospital. A revenue limit for a system would be considerably more flexible than a limit on each individual hospital. If the growth in technology is, for example, limited to 2 percent, the flexible use of such funds within a vertical system could be of considerable advantage to the total system.

Unfortunately, a hospital rate-review program tends to take the narrow view of separating out the hospital and

outpatient care from the other activities of the corporation. The flexibility of the vertical system to operate as one integrated unit would be limited if the payment programs continue to be fragmented. The rate-review program, rather than become a unifying system, will probably isolate and regulate the conventional patient services provided by a hospital. Other services of the vertical system — such as skilled nursing facilities, intermediate care facilities, and home health nursing — will most likely continue under the present cost-reimbursement system.

The vertical system has the potential for a more flexible use of both operating and capital funds in spite of the many negative aspects of current reimbursement programs. The financial advantages are likely to increase in the future as revenues available to the total health care industry become more restricted.

The most obvious financial advantage of a multiinstitutional vertical system that is centrally owned and managed is in the area of capital financing.

CAPITAL FINANCING

The old adage that there is “safety in numbers” seems to apply to corporate finance, although one can, no doubt, think of notable exceptions. The combination of two or more institutions into a single entity tends to increase the debt capacity of the new entity to an amount in excess of the total of the individual debt capacities of the merged institutions. Because of the short-term outlook that is typical of government regulators, the importance of capital financing in the acquisition of facilities will probably continue to increase. With the emphasis on control of health care prices, either voluntary or mandatory, substantial capital formation is not likely to occur in the health care industry. The increased borrowing capacity of a multiinstitutional vertical system through its increased size and diversity of operations is an important advantage.

CATEGORICAL PROGRAMS

In the absence of an established vertical system that coordinates all health care activities, many categorical programs have been initiated that assign institutional linkages with no consistency from one program to another. Although a program such as the Poison Control Center would be inappropriate to duplicate in every system, there are others that could be consistently organized. The networks for perinatal, cardiac care, cancer, end-stage renal disease, and trauma programs could have consistent linkages. These categorical programs might

provide the nucleus for other cooperative ventures as the opportunity arises. The availability of outside funding seems to be a great incentive for cooperative efforts.

FUTURE OUTLOOK

The financial aspects of a vertical health care system tend not to be very different from those of any large hospital or group of hospitals. The vertical system has more diversity of operations with the corresponding regulatory complexities. A fully integrated vertical health care system in a large community with competing systems would clearly have a favorable impact on accessibility, continuity, and quality of health care. It would also provide the opportunity to take advantage of the economies of scale in medical, health delivery, and other programs that would not be available outside the system.

One of the hazards of a large health care corporation such as was proposed by the American Hospital Association in the early 1970s is that it is a made-to-order regional health program that could be part of a national health system. The historical pluralistic methods of delivering health care services and consumer choice could be lost in such a highly organized system.

A ceiling on health care operating and capital expenditures could easily be applied to each of the systems. However, if we expect that such controls on hospital expenditures will be established in the future, the vertical system would have a great deal more flexibility than a single independent hospital.

As biased as I am toward the theory that finance is what makes the world go around, it is unrealistic to believe that there will be a major movement of independent, autonomous, secondary hospitals wanting to merge into a vertical health care system with one of the major medical centers.

Although the financial synergism does not exist in a system of affiliated institutions, there are many mutual advantages to the participating institutions, medical staffs, and patients that make such a system worth doing.

It will take many years and continuous efforts to develop reasonably comprehensive working relationships in an affiliated system. The patient care programs and administrative programs will develop very slowly and unevenly between each of the affiliated hospitals and the medical center. Significant relationships between the individual affiliated hospitals may never develop without some centralized management.

For a health system to be meaningful it needs to

operate in an environment with other health systems, each providing a fair share of service to the "medically underserved" population and health manpower requirements. The Chicago area has the potential to develop such systems, but the incentives for the medical centers to promote a large integrated vertical system and for the

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other institutions and their medical staffs to participate actively are not sufficiently strong at the present time to make this a reality.

Internal Organization and Management of Vertical Health Systems

ROBERT P. BRUECK

CHAIRMAN REED MORTON: Our final speaker this afternoon is Robert P. Brueck, who is president of the Center for Health Studies, an affiliate of the Hospital Corporation of America. His topic is the "Internal Organization and Management of Vertical Health Systems."

ROBERT P. BRUECK: Thank you, Reed.

The internal organization and management of vertical health systems is a topic that is neither well covered in the literature nor exemplified in any existing organization model. My perspective derives from experience in a dynamic, successful, but horizontally integrated organization with its focus on short-term, acute-care general hospitals. While it is instructive to note that there are no complete examples, the Rush-Presbyterian-St. Luke's complex in Chicago, the Greenville system, and the Kaiser-Permanente complex most nearly approximate vertical structures.

Where vertical integration is feasible—where there is financing and critical-mass scale—the consummate structure may appear in the future. However, in its conception, a vertical health system is anomalous, even paradoxical. It is a corporate behemoth appearing in an age nostalgic for simplicity and distrustful of financial giants. It implies a more orderly delivery of health services which have historically been scattered, diverse, and intensely personal, dependent as they are on the genius of the physician and the dedication of professionals at all levels to the care of the individual patient. A vertical organization will indeed be a paradox in itself; a pyramidal megastructure of capital and management that will not only meet individual human needs at a given moment in time but will accommodate itself to changing perceptions of the very function of health services.

Responding to some of these incongruities, this paper adds another contradiction in terms of the possibility of controlled decentralization. And it submits another paradox, namely, that a management system may be borrowed from a company which builds integrated circuits and incandescent lamps. With some modification, General Electric's concept of the "strategic business unit" seems to be a promising management system

for a vertical health service structure. An effort will be made to provide some insight into considerations to be made for the internal management and organization of vertically integrated health systems.

I. BACKGROUND

Scope

First, however, it is essential to know what is to be managed. A useful starting point may be a macro view of the environment in which a vertical system might operate. As a matter of convenience, health care may be described by a continuum, allowing for much overlapping and many fuzzy areas. The first segment is the *hospital* complex, directed to the acute care and treatment of the sick or injured. The second segment, and the limit of focus of this paper, may be designated as *health services* and includes long-term and rehabilitative care.

Beyond health services on the continuum come research and development and the manufacture and distribution of a wide variety of products essential to total *health care*. An imaginative individual could easily extend the set to include housing, hygiene, and other factors affecting society's growing expectations for the *quality of life*.

Range of the Health Services Segment

Under the aegis of the health services is a broad array of providers and provisions. (For a summary of the health service market, see fig. 1.) Enumeration of the five major entry points available to the individual who needs or thinks he needs health services will convey the enormity of the field.

The first entry point is *self-care*. The individual has available to him the drugstore, his friends, the media, and educational programs and materials from a plethora of institutions and associations.

Second, the individual has access to *ancillary practitioners*, such as faith healers, chiropractors, acupuncturists, hypnotists, and midwives, and including a proliferation of nonphysician primary providers trained in inhalation therapy, physical therapy, audiometrics, optometry, and the like.

Third, the individual may obtain health services through such *outpatient facilities* as emergency rooms, trauma centers, or stationary or mobile diagnostic

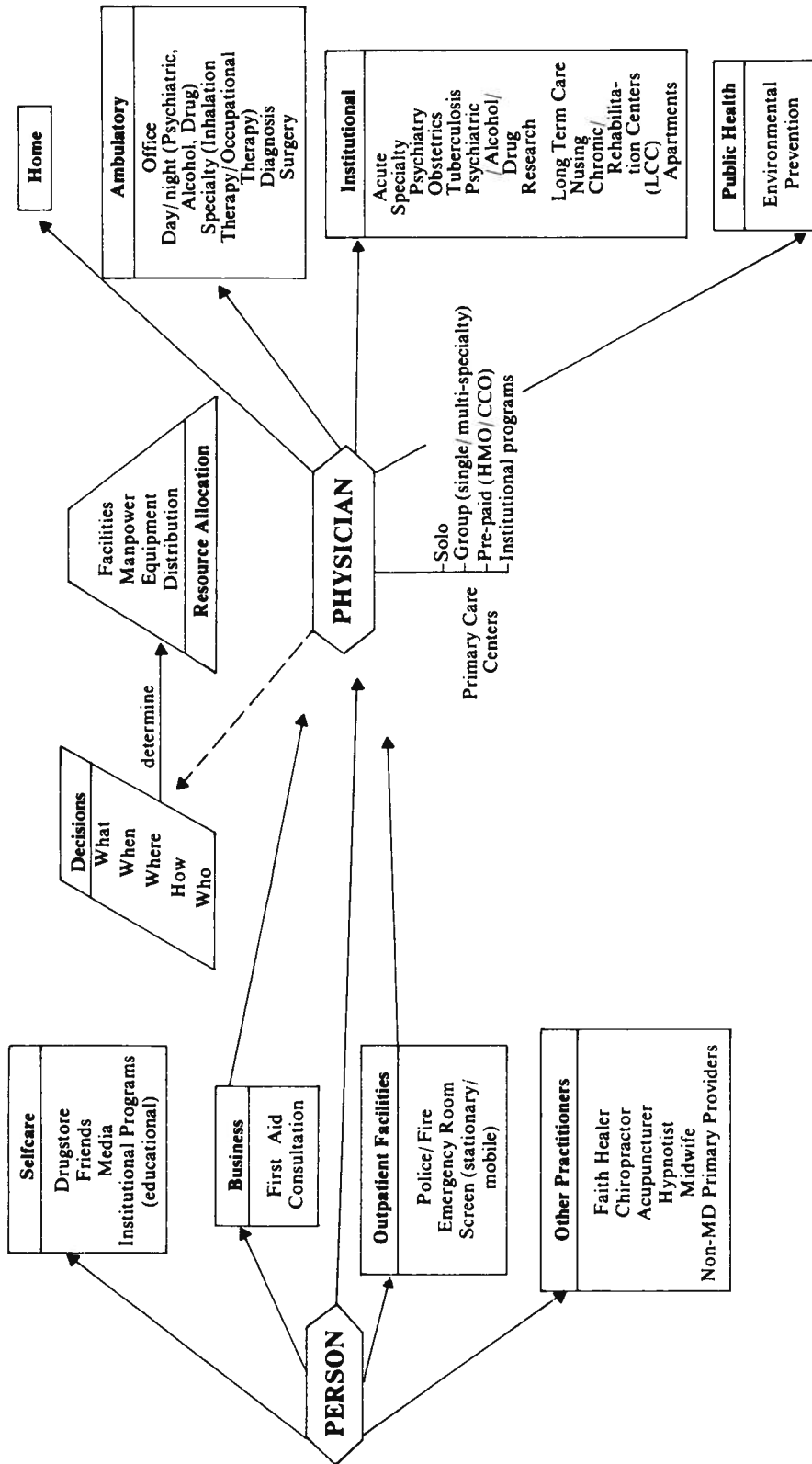


Fig. 1.—Health services market

screening centers. Associated with these facilities is a variety of skills and equipment, including police, fire, and paramedical personnel equipped with helicopters, electronic monitoring systems, and communication devices.

Business and industry provide a fourth avenue of access, beginning with first aid and expanding to consultation services, including physical examinations, screening, emotional and spiritual counseling, and adding, as a corollary of safety consciousness, plant environmental and safety inspections.

Finally, the individual has direct access to physicians. He or she may directly or indirectly receive the attention of a doctor at any of the four entry points mentioned already or may proceed initially to a physician. Choosing among a bewildering array of general practitioners and specialists can be a formidable problem for a medically unsophisticated person in the emotional stress of needing health care. Although there are still many—and will continue to be many—solo practitioners, there are an increasing number of group practices (both single and multispecialty), prepaid group plans, and various types of institutional programs. Many of these arrangements may incorporate primary-care centers and other outreach programs.

From the myriad points of entry, the physician chooses various avenues of treatment. The first of these is *home care*, an increasingly popular choice and one to which physicians and other primary providers are responding more and more. Businesses and agencies also provide home health services, ranging from instructional programs to hygienic service and the provision of nutritious meals. Citizens are increasingly interested in arranging to care for the aged, infirm, or handicapped in their homes.

A second avenue of treatment falls under the rubric of *public health* and encompasses not only clinical facilities but sanitation, pollution control, and prevention of disease. Although public health has been the exclusive domain of government, new laws and regulations will doubtless open the field to nongovernmental entities as well.

Ambulatory care, another expanding avenue of treatment, will grow even more under the stimulus of regulation and third-party payment sources, as well as the concern of individuals for more convenient services at lower total cost, including less time away from work. Advances in technology also lend impetus to the expansion of ambulatory care, so that these services range

from visits to physicians' offices, or to emergency rooms or clinics, to day and night care for psychiatric, alcohol, and drug therapy; specialty services for inhalation therapy, occupational therapy, and rehabilitation; diagnostic services in fixed and mobile units; mass immunization programs; and ambulatory surgery centers. These and other more imaginative services will call for greater utilization of paramedical personnel, together with increased use of technological advances for communication, monitoring, and diagnostic applications.

The fourth avenue of care is *institutional care*, focusing, most frequently, on the episodic treatment of illness. It includes not only acute-care facilities but an assortment of centers for specific purposes, such as psychiatry, obstetrics, alcohol and drug treatment, and research for certain diseases. Long-term units extend this category to nursing homes, chronic and rehabilitation centers, and facilities for domicile care.

Central Role of the Physician

It is obvious from this litany that no one group or organization could or would want to embrace the comprehensive provisions of all these health services. They do offer a number of opportunities which may pertain to a given area of organization. It is obvious, too, that the physician is the central figure in the provision of most health services. While there is evidence to suggest that the centrality of the physician may be diminishing as HMOs and other comprehensive care modules gain acceptance, a rational conclusion is that the treatment skills and knowledge of the physicians will remain paramount for at least the next decade. The physician determines who will be cared for, when and how and where the treatment will be carried out, and what kind of care will be provided. Physicians, then, are the primary "customers" of health services, although other people may be the ultimate users.

Conflicts

Decision making.—The physician's judgments will determine resource allocations in a vertical system in terms of facilities, manpower, equipment, and distribution. No health organization can prosper unless it has recognized that, though managers make pronouncements, the physician makes the ultimate decisions as a part of his professional commitment.

Business, too, will affect decision making, both in financing health services and in influencing the details of organization and management. As costs increase

owing to inflation and advances in technology, greater economic pressure falls on employees and redounds eventually to their employers. In addition, the sociopolitical stimulus to provide "more for less" yields strong demand for the employer to "do something." That "something" will undoubtedly be greater interest and action on the part of business and industry in examining alternative arrangements for the purveyance of health services.

Conflicting objectives.—When managers, physicians, and business leaders, with their sometimes conflicting objectives, sit at the conference table, their thinking will be affected by the increasing public expectation of remaining healthy as opposed to undergoing episodes of intensive treatment for illness. The present scheme is geared to the episodic treatment of a series of illnesses requiring the individual to initiate action. Society in the future will expect health services to provide for health, not for illness. Doctor Eric J. Cassell, in a recent *Wall Street Journal* editorial, makes the point that American medicine is not a "health care system" but a "sickness care system"—and a very good one. He points out that the two problems, conquering disease and achieving a healthy population, must be addressed separately, and he adds, "It is probable that different concepts and methods or even different personnel and institutions will be required."

Conflicts in the objectives of the system's disparate components are likely to intensify with this shift in focus. It is imprudent to expect a manager to increase the census in an acute-care hospital facility and at the same time to strongly promote ambulatory modalities designed to reduce hospital utilization. Inevitably, he will favor that for which there is the greatest incentive. While it is true that both an HMO and an acute-care hospital have the same ultimate goal of producing a well person, it is naive to assume that the same methods are common to each. Moreover, it is unreasonable to assume that a single manager will do justice to both, no matter how well intentioned he may be. Doctors, nurses, and paraprofessionals have skills to take care of disease and injury and do so very effectively. Management, however, must not confuse care of the sick with health care. If both kinds of care are to be included in the vertically integrated system, pains must be taken to avoid dual and conflicting objectives. To do otherwise will inevitably lead to a schizophrenic posture when the time comes (as it always does) to allocate limited resources of manpower and capital. The winner in this

competition will be that for which there is the greatest incentive, be it money, prestige, power, personality, or popular fad.

Need for Leadership

Leaders of health service systems must beware the narrow vision, must refrain from directing society to a fixed future which they have already predicted and to which they are committed. Strong leadership must emerge to assure the social value of great vertically integrated health structures. In the context of this symposium, it may be superfluous to ask where the leaders are to come from. Nonetheless, the demand for strong leadership comes at a time in the United States when many people notice a dearth of leaders. In an article published in *Business Tomorrow* by the World Future Society, John Naisbill says,

We have no great captains of industry any more, no great university presidents, no great leaders in the arts, or in labor, or in politics. It is not because there is any absence of ambition or talent on the part of those who would be leaders. We don't have any great leaders any more because we followers are not creating them. Followers create leaders—not the reverse—and we followers are not conferring leadership as we did in the past. We are now creating leaders with much more limited mandates; closer to us and on much narrower bands.

A leadership for vertical health systems must emerge to resolve the conflicts that have been named: conflicting professional and business interests that affect decision making, conflicts between the present system of treating illness and society's growing expectations of health, and conflicts in the objectives of the separable units.

II. MANAGERIAL CONCERNS

Critical-Mass Scale

These conflicts either reside in the background or loom in the future. Several more immediate internal-management postulates and constraints must be confronted and resolved before a vertically integrated system can come together. Vertical structure assumes a certain critical mass, a certain confluence of people (patients), doctors, nurses, paraprofessionals, build-

ings, equipment, and money. It is difficult to envision a totally integrated system for a town like Erin, Tennessee, where Hospital Corporation of America has a thirty-one-bed hospital associated with a small group of independent physicians who have a reasonably good referral system but not within one organizational structure.

Few locations can support a vertical organization without subjecting sick people to even greater inconvenience and restriction of choice. Sites where the necessary critical mass can be assembled are probably limited to large urban hospitals, medical schools, and health care corporations. Even within these confines, matters of size, resources, and present focus enforce further limitations. Fewer than 600 hospitals in the United States have more than 500 beds, and a number of these barely have the resources to carry out their present function.

Medical schools offer a logical center for vertical integration, but, again, they are limited in number. In the December issue of *Modern Health Care*, Dr. James A. Campbell, president of the Rush-Presbyterian-St. Luke's Medical Center, predicted that "university teaching hospitals will become the anchors of vertical multi-hospital systems" and warned that "if we in the voluntary sector don't form these networks, we may be very well forced into it." Campbell may be right. The reason may be contrary to his thinking. There are 125 medical schools in the United States. In view of the problems which the federal bureaucracy has in controlling 7,000 hospitals, consolidation would certainly appear to be an attractive socialization option to the regulators. Some pragmatic problems come to mind, however, in trying to contemplate tertiary patient referral by doctors in Erin, Tennessee, to doctors at Vanderbilt University Hospital, just sixty-five miles away.

Health care corporations, even insurance companies, may also be logical focal points; however, many of the multifacility companies appear to be moving in the opposite direction as they carve out a particular niche of specialization and find greater incentives for horizontal integration. Integration could be accomplished, nevertheless, through management arrangements, acquisition of service units, and construction of facilities where they are needed but do not currently exist.

Constraints on Vertical Integration

Capital.—Acquisition and construction require capital, which is both a part of critical mass and the first of several constraints on vertical organization. Capital

must come from government in the form of taxes or from business in the form of profit. Debt capital must generate profits in consolidation, recognizing that some systems will elect to break even or even lose money on some aspects of their operations. A basic structure to the vertical system, an HMO, for example, requires a seven-year payback period, a long time for a new and rapidly changing organization. Hard decisions will need to be made by people who are skilled in the capital market and who have the imagination and the nerve to pursue different sources and kinds of arrangements.

Physicians.—Perhaps the greatest constraint on the creation of vertical networks is physicians. Campbell points out that university-affiliated physicians are "busy" and nonacademic physicians "fear for their business and autonomy." Physicians, not hospitals, refer patients, and it is imperative to determine and satisfy their needs. For the most part their attitudes and organization do not correspond favorably to the interests of a vertical structure. An organization cannot easily change established patterns developed by physicians on a very personal basis. Moreover, the trend among physicians has been to organize themselves in various kinds of group practices, the favored one being single-specialty groups. Between 1965 and 1969 the number of group practices nearly doubled. The growth continues, and today there are probably more than 10,000 groups. Any vertically integrated organization must be prepared to work within the patterns of referral and organization adopted by physicians. The literature furnishes few clues as to how this may be done; nevertheless, there is no substitute for strong physician leadership in the creation of vertical structures.

Internal constraints.—Once critical mass and physician leadership have come together with large amounts of money, constraints turn inward to managerial expertise, financial ability, and technical skills required to operate a vertical structure. None of these is easy to obtain. Financial ability comprises skills in the generation of revenue, maintenance of margins, and deployment of capital for the careful handling of investment. This implies a good but not cumbersome budgeting and monitoring technique, probably with the help of computer technology. Technical skills, other than clinical, are required at a central level to carry out those informational functions essential to large organizations and those for which scale provides some economy. Such necessities as data processing, communications, legal services, auditing, finance, real estate, engineering, and

many others lend themselves to central control. Finally, management expertise at all levels is needed to tie it all together. Hospital Corporation of America has been doubling its size every three years and multiplying accordingly the numbers of skilled managers who must, especially in a highly decentralized management mode, be oriented to company philosophy and procedures. In recognition and as a partial response to this need, the Center for Health Studies was created to provide educational programs for the executive and middle management of the company.

Regulation.—Another constraint is regulation, a way of life for health care providers that is likely to increase in magnitude, cost, and trouble. Regulation affects cost controls, franchising control, reporting and disclosure, and a maze of procedures related to construction and licensure. In addition, the organization must be concerned with quasi-legal controls imposed by such groups as the Joint Commission for Accreditation of Hospitals and various Blue Cross plans. These controls affect reimbursement, an intense function that requires a highly skilled staff. Regulation also mandates a specially oriented legal staff to engage in negotiations and litigation. In fact, increasing sociopolitical pressure will make the development and growth of vertically integrated systems very difficult. Although the proponents of such systems advocate on logical grounds that the vertical system should be exempt from certificate-of-need requirements and similar restrictions, it is doubtful that nonaffiliated institutions and physicians will quietly agree to immunity for this one organizational category.

Social response.—Above statutory and industry regulation stand the principle of service and the concomitant need for social responsiveness. It is a truism that organizations exist to serve the needs of the society. When any organization no longer does this, it will, sooner or later, cease to exist. If vertical systems are to develop and endure, their leaders must be sensitive to the public will and to the complex interactive psychodynamics of a society in transition from a goods-producing to a professional and technical class society, and beyond to a knowledge era. Receptivity to large-scale vertically integrated systems will be difficult to judge in this milieu.

Leadership will require courage and determination to protect the franchise, insure growth, and at the same time be responsive to social change. In order to do this, skilled staff personnel must honestly and objectively

assess the organization, both internally from the point of view of strengths and weaknesses, constraints, and opportunities, and externally from the perspective of changes in demography, technology, economy, sociopolitics, and the industry. The competition and the customers are both complex and determined. As the Center for Health Studies has found, it is difficult, time consuming, and expensive to draw trend lines, determine inflection points, and assess impacts on the market and competition.

III. THE STRATEGIC BUSINESS UNIT CONCEPT

All of these concerns must be addressed in organization: a strong and imaginative leadership, with the physician playing a prominent role; a critical-mass scale; an attitude of social responsiveness; and an ability and willingness to deal with restraints, both financial and regulatory, and with the conflicting purposes of separate health service units.

The concept of the strategic business unit (SBU) developed by General Electric Company combines economies of scale appropriate to a large business structure with the autonomous management of each of the smaller units of that structure. General Electric originated the concept as a means of practicing strategic issue management within an organizational framework. The units may vary greatly in size, from a group or a division to a department, so long as each one is a self-contained, viable business unit operating in a clearly defined market. In the health systems, some of these units may need to be in physical proximity to other self-contained units.

The general organization suggested is a corporate structure. It should have a board of directors responsible for the total corporate strategy and financial and moral policy of the entire organization. The directors should be served by a separate medical advisory board, such as the board of distinguished physicians comprising the Board of Governors of Hospital Corporation of America, a group that advises the company relative to medical and technical matters. The board of directors should have a primary responsibility to employ a competent chief executive officer with courage and vision who will in turn employ skilled staff assistance.

A central corporate services staff consisting of highly competent people will perform those functions which require centralization or lend themselves to economy of

scale or require a high level of coordination for financial or legal reasons. Among these functions are finance (including capital allocation), legal services, government relations, real estate, research and development, central accounting, human resource data and reward systems, information services related to data base and data handling, some purchasing and materials handling, some public relations, technical reimbursement expertise, construction, and internal auditing.

At an intermediate level, the strategic business groups would recognize the differing and sometimes opposing objectives of the various health services and would be coordinated under the management of an executive group made up of the chiefs of each of the SBUs along with the chief executive officer.

The individual units may vary according to the level of maturity of the corporation and each unit, as well as the personal viewpoint of the chief executive officer and the board of directors. They would undoubtedly change from time to time. Generally, they may be hospital service groups; independent ambulatory service groups; long-term care group; environmental groups, including business health and preventive programs; a physician group; and perhaps an international group. Depending on the extent of development, there could well be SBUs within each of the groups named. Each of these SBUs would be divided further into geographic area or type of service or specialization.

Each unit would receive direction by relatively autonomous managers with appropriate staff support. It should be considered desirable that such support would duplicate some services, either at the corporate level or in other units. To assure a high level of quality control, responding favorably to the needs of local society, each unit should have the benefit of a local board of trustees. The bridge used to tie the central services and the several SBUs together should be a "knowledge-transfer" function of managerial education and strategic planning.

Obviously, there are many variations to this approach which require accommodation to the circumstances. Such a scheme, however, could diminish conflicts in the objectives of separable units, provide a means to mediate competing resource-allocation requirements, create career advancement and training opportunities, and offer a mechanism for control and evaluation at both the unit level and on a global basis. In the span of a short paper on the subject, more must be omitted than reported. For example, the technique used by General

Electric and advocated by such experts as the Boston Consulting Group for resource allocation is the business matrix which serves as a tool to examine markets and utilization. This alone could (and has been) the subject of one or more papers.

While many local or mini-systems may emerge, the vertically integrated health structure will not be a dominant system of this decade. It does offer an alternative in those circumstances where all of the ingredients can come together. Nor will the goal, for those who choose it, come quickly or easily. Yet the vertically integrated network can combine the advantages of the corporate structure with the advantages of decentralization, where each unit is small enough and its services sufficiently focused so that one manager, with his advisers and staff, can encompass it. To attain the harmony of the parts and the whole, which is the meaning of integration, several points must be kept in mind:

1. Strategic planning should be skillfully coordinated, especially for resource allocation and the development and promotion of the mind-set or philosophy of the organization.

2. Control and evaluation techniques must be devised at each level consistent with the point of decision for action to be taken. (This is, perhaps, the most difficult aspect.)

3. The vertical network should have a decentralized management mode under the direction of strong, independent managers.

4. Units must be kept small as possible for compassionate, personal service.

IV. CONCLUSION

This last—compassionate, personal service—must obtain, not merely to counter the prevailing view that bigness is synonymous with depersonalization to assure corporate survival. It must obtain because the health service business is linked to the healing arts and to improvement of the quality of human life. The humanist-physician, Dr. Edmund D. Pellegrino, reminds us that *compassion*, "to suffer with," and *patient*, "to suffer," derive from the same Latin word. Compassion means, literally, "to bear together, to share in another's distress, and to be moved by desire to relieve distress." Pellegrino points out that "the focal point on which all medical activity converges is a choice of those that should be done for this person, at this time, and in this life situation." This function of choice, he adds, is dis-

tinctively that of the physician, though "all health professionals participate to some degree."¹ If health systems do not attend to their moral and spiritual responsibilities, if they fail to maintain an equilibrium between profits and altruism, between the day's pressing business and enduring human values, they have failed in their institutional function and they have failed the individual. This nation has not yet reconciled insti-

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tutionalism and individualism, two of the seemingly conflicting watchwords of our time. This, then, is the greatest constraint: to build, under divine guidance, an even greater, more elaborate health system to care for "this person, at this time, and in this life situation."

¹Edmund D. Pellegrino, *Humanism and the Physician* (Knoxville: University of Tennessee Press, 1979), pp. 226-29.

General Discussion

REED MORTON, CHAIRMAN

CHAIRMAN MORTON: We have time for some questions; are there any?

ODIN W. ANDERSON: Did you say that for the health care system and the illness care system, two different organizations with different missions are needed?

ROBERT BRUECK: What I am suggesting is that one individual needs to focus on each of the kinds of services we are talking about. Within one organization, you can certainly have both, but you cannot give the two responsibilities to a single person.

SAM FRIEDE: Mr. Oder, you commented on the boundaries for health care systems starting with the university and going toward long-term care. How would you view such activity as equipment rental and retirement centers? Would you include those?

DONALD ODER: I would certainly put equipment rental in the category of administrative and support services which ought to be obtained in the most economical way without regard to whether a system exists or not or where it is coming from. It is just a necessary service and has essentially nothing to do with provision of health care. You just want to hold the cost down. On the retirement centers, it seems to me that is also outside of what I would call the provision of health care. That is a residential-custodial function. I think that somewhere you must draw a line and say, this is health care and this is not. Although equipment rental and retirement centers could be part of "broadening the base."

PAUL A. HOFSTAD: It seems to me that the vertical systems that have been discussed here are a never-never land, and are there not ways to develop vertical systems without going through university centers? I would like to see if we can get back down to earth; is there a different style or type of vertical system?

MR. ODER: Of course, anything is a matter of degree and of how complete you want the system to be, and that is the drawing of the line. Do you include a retirement center? Do you include the production of the manpower to carry out your mission?

Nurses, for example, are very difficult to obtain. It seems to me that to educate sufficient nurses for a vertical health care system would be an important part of having a complete system, and I think most of you would

agree.. But where do you go from there? What about medicine? Perhaps you would want graduate medical education in the system, but perhaps not. Then do you include the medical school itself? And what about the other health professions? Some technical schools are already in hospitals, such as the schools for medical technology and radiation technology.

I think you can have a vertical system if you have nothing but a single hospital. What we are talking about is the extent and the completeness of the system.

MR. HOFSTAD: So you could have a mini-vertical system.

MR. ODER: Or you could have mini-vertical systems which are affiliated in some way with these other kinds of services needed to complete the system.

MR. HOFSTAD: As Odin would say, that would be many microsystems making up the macrosystem.

RICHARD JOHNSON: Bob, I would be interested in your comments: You have been on both sides of the fence in your career from the standpoint of the nonprofit versus the for-profit side. I still keep wondering about the question, What makes Sammy run? You seem to be skeptical about where vertical systems will go, and with that general context, what do you think about the impact of equity in a situation, how it drives people? Does it make them different? Does it make them want to build these systems?

MR. BRUECK: I do not think that the ability to obtain equity capital through the market for a profit system alters very much the interest or the incentives to develop vertically integrated systems.

I think what we must consider, for a for-profit or a not-for-profit organization, is whether we are in a position to respond to whatever the needs are in our areas. And I seriously doubt that there are very many people who are saying that a vertically integrated system is a great idea so let's build one, *unless* it can be demonstrated that there is a need for it and it is financially feasible. It does not seem to me, Dick, that it makes a lot of difference whether we are talking about a for-profit or not-for-profit system. So I think we are going to see many units at the individual hospital level as well as the multihospital level in which there are vertical elements,

but we are not talking about a completely integrated system which takes into account all of the entry points and all of the various applications.

We are going to be responding to whatever is necessary, but for-profit or not-for-profit, I think, is immaterial.

MR. JOHNSON: Both Don and Bob talked about leadership and its importance. But where does it come from, and is it enough? I think that there has to be a stick to push people. Leadership has to be backed by leverage and Don said leverage does not exist in affiliation-type of systems. I would be interested in your thoughts about that.

MR. BRUECK: I agree with what Don said: It is much easier to manage the structure if you own it than if you are trying to operate by affiliating arrangements. I am certainly going to choose the system with complete ownership; we won't consider a partial ownership. The way to go about getting the leverage you are talking about is through ownership, and if many of the non-profit kinds of arrangements result simply in loose affiliation and not ownership, it becomes that much more difficult to manage.

MEMBER: This question is for Bob. I recognize that you emphasize the predominant role the physician should play in the system, and I wonder whether you might give equal provision for emphasizing the management implications of the physician's role. If you make the other staff sensitive to the physician's primary situation, what pains do you take to insure that the physician is aware of the economic consequences of the decisions?

MR. BRUECK: We persuade the physician to recognize the economic implication of some things. It is a bit easier to do in some foreign countries where they have a considerably greater economic interest in the total operation. The physicians have the primary care, the primary

activity dealing with such things as laboratories and X-ray, and they are going to be much more aware of some of the economic implications. The only thing that we can do is to try to involve the physician to the greatest possible extent in the total management of the facility, and we do this on the local level with the local board of trustees. We have been very fortunate in being able to let them know the kinds of problems that we are up against and the effects of our actions on their incomes. If we can demonstrate some favorable responses for them, they will be interested in what we are doing.

MR. ODER: May I comment on that. I certainly agree with Bob that physicians are key to the system; the fact that Rush signs an affiliation agreement with a particular hospital may do nothing whatsoever in the referral of patients because the hospitals do not refer, the physicians do. So the only reason for that affiliation may be the hope that over a number of years the physicians at an affiliated hospital become better acquainted, through medical programs, departments, and educational programs, with physicians at the center, and eventually the center gets more referrals.

One of the fallacies of the planning system is a belief that, if we want to put in a second catheterization laboratory or something in the X-ray department, we can say, "Since we have this great network, we can get letters from all of the institutions indicating that they are going to refer to us." Of course, we can do that, but it means absolutely nothing because those *hospitals* do not refer, only the *physicians* do.

CHAIRMAN MORTON: I certainly want to thank both of you, and the audience as well, for your participation and your comments.

The Future of the Traditional Hospital

EARL G. DRESSER

The third session of the Twenty-second Annual George Bugbee Symposium on Hospital Affairs met at the University of Chicago Center for Continuing Education at 9:00 A.M., Friday, May 30, 1980, with Richard W. Foster presiding as chairman.

CHAIRMAN RICHARD FOSTER: Good morning and welcome back. I see from the number of faces out there that there are some of you with questions we did not get around to answering yesterday, one of which is, no doubt, the question to be addressed by our next speaker. Earl Dresser is president of the Methodist Hospital in St. Louis Park, Minnesota, and his topic is "The Future of the Traditional Hospital." He is well qualified to address that subject for a number of reasons, not the least of which is that he is bright and could speak on almost anything we asked him to.

Since it is in the Twin Cities area, Methodist Hospital is in the midst of what some people believe to be a hotbed of an organization which will eventually supplant the traditional hospitals, so it will be interesting to hear from him from that perspective. Earl also tells me that Methodist Hospital is the only hospital in the Twin Cities which is not part of a multiinstitutional system, so he is certainly in the middle of everything.

Earl, it is a great pleasure to have you, and we look forward to hearing what you have to say.

EARL G. DRESSER: Thank you very much, Dick. With an introduction like that, I am afraid that you raised their expectations too high, but, Odin, I was very honored to be invited by you to address this group. This annual George Bugbee Symposium on Hospital Affairs enjoys an excellent reputation in our field, and I am grateful to have had the opportunity to be with you the past two days. Several of my peers from the Twin Cities area are Chicago alumni and are here today, so I will have to exercise some restraint in my comments. Most of the time we have them outnumbered by Minnesota alumni up there, but they have me on their home ground today. However, with an Anderson and a Johnson having responsibility for this program, I feel right at home.

I have assumed that the reason I was asked to present this paper is related to the fact that I am the chief

executive officer of a single, free-standing hospital in the midst of a metropolitan area which has long been known for its shared services, multiinstitutional systems, and proliferation of HMOs.

In thinking about my assignment, I tried to define a "traditional hospital." I finally abandoned the attempt to find a precise definition because this term has various meanings, depending on who is trying to define it and for what purpose.

My efforts to project the "future" were equally frustrating because of the variables that affect the hospital, depending on its size, setting (urban or rural), competitive environment (single-institution or multiinstitutional community), range of clinical services, and many other factors.

So today I am taking the easy way out by describing our situation at Methodist Hospital and the soul-searching we have done in our attempt to define the future of our hospital. The point of this has been to ensure our hospital's viability so that we could continue what we consider to be a necessary and progressive program of health services for our community.

Methodist is one of the last (but not the only) single-hospital corporations in an area of multihospital systems and merged hospital corporations. It has approximately 450 beds and is located in a suburban setting with a well-defined service area.

Because of the medical specialty character of the medical staff, the hospital has a broad range of clinical services. Fifty percent of its patients are referred from outside the primary service area, and 20 percent come from outside the metropolitan area, from upstate Minnesota and western Wisconsin. The average length of stay, based on diagnostic-related data, is the lowest in the metropolitan area, and the cost per admission is one of the lowest in the area. For the past seven years, we have been the primary hospital for one of the fastest growing group-practice HMOs in our area.

We have not been oblivious to the changes taking place in health care delivery all over our nation and particularly in our community. Furthermore, it should be noted here that we have a surplus of beds in our area. You are no doubt also aware that due to the rapid proliferation of HMOs in our area, the concept of "price-level competition" is fast becoming a reality. Add

to this a militant regulatory system, which tightly controls capital expansion, the units of service we produce through a strong PSRO, and the price of these services through rate review, and you have an understanding of the significant elements in our operating environment.

We have given much thought and planning to our specific situation. Frankly, we recognize some weaknesses in our present organizational structure, and we are concerned. While we are not committed to defend our complete autonomy to the bitter end, neither do we have the insatiable "urge to merge," as we describe this phenomenon in our area.

Our concern had led us to reexamine our objectives and to revise some of them where necessary. We have made a conscientious effort to determine what kind of a hospital we want to be and what kind of a hospital we should be within the context of the community we serve and our commitments to our other constituencies. This led us to what we consider to be an objective self-assessment of our strengths and weaknesses. After agreeing on our objectives, we wanted to be able to gauge our ability to meet these objectives. While the following is not an exhaustive list, it includes some of the factors, both internal and external, we considered in this assessment.

The internal factors include the following:

1. *Relative obsolescence of physical plant.*—We have a relatively new physical plant. The oldest portion of it was completed twenty years ago.

2. *Present financial viability.*—We have enjoyed a relatively good occupancy which has allowed us to meet our debt service and to provide the other legitimate capital needs of our hospital. We have a relatively strong balance sheet. Actually, one of the deterrents to considering seriously some previous proposals of merger by other hospitals was the fact that they needed our balance sheet worse than we needed theirs.

3. *Economies of scale.*—Our situation here is somewhat marginal. While we have been able to satisfy our capital needs and, up to this point, stay abreast of increasing demands for high-cost technology and greater management and clinical expertise, we are concerned by our ability to keep up with these demands in the years ahead at our present size and level of utilization. Present inflationary trends give cause for still greater concern.

4. *Need for broader financial base for new services, teaching, and research.*—We have a concern here which

is the same as the one stated in 3 above. While research is not a concern of ours and we are minimally involved in medical education, the ever-growing demand for new services, many of which are not directly revenue producing, presents us with considerable challenge on our limited bed base.

5. *Need for new technology.*—We have two concerns here: our continued ability to finance new technology (as I have just indicated) and, probably of equal concern, our ability to provide the volume of activity in the utilization of this new technology, which will meet the planning guidelines required to obtain a certificate of need. One of our deep concerns at the present time is our ability to replace our CAT scanner, because our volume of activity is just slightly under the guidelines.

6. *Strengths of the medical staff.*—We have a relatively young, aggressive staff which represents all of the major specialties and subspecialties of medicine. Our one weakness is a limited primary-care base to support adequate referrals to the medical specialists. Lack of a referral base plus an inability to remain on the cutting edge of technology, as described above, could create problems for us and our specialty medical staff in the future.

7. *Strength and depth of management.*—In most positions, our management staff is excellent. However, as external pressures in the regulatory environment increase, it is becoming apparent that we are thin and need to increase the depth of our staff. This is one of my major concerns because we have gone about as far as we can in providing management expertise internally on our limited bed base. It is my personal opinion that we are somewhat undermanaged at this point, and the situation is growing worse. We must find a way to respond to this need.

8. *Governance.*—This is the most important factor for assessment; in a very real sense it is the "bottom line." Unless the governing board is knowledgeable, committed, and willing to deal aggressively with the issues we have just mentioned, the future of the hospital is pretty bleak. We have a solid core of knowledgeable and dedicated leaders. We think our thirty-two-member board is much too big to move aggressively in our dynamic environment. A board of twelve to fifteen with the qualities we have just described would be more effective in making decisions on policy and providing direction for our hospital. Obviously, there are other

important qualities that must be assessed in determining the board's effectiveness to deal with the issues of the day. Time does not permit a more definitive description of these qualities here.

Some of the external forces that we considered are:

1. *Bed reduction and consolidation of services.*—The public pressure for this in our area is strong. Our HSA is committed to eliminating 2,000 beds in our metropolitan area by 1983.

2. *Certificate of need and appropriateness review.*—These present challenges to a hospital such as ours in our ability to develop new programs and remain on the cutting edge of technology.

3. *Reimbursement and rate review.*—These forces, of course, are significant challenges to all hospital corporations. Our problems are neither significantly greater nor different from other hospital corporations in our community. We have found it necessary to continue to upgrade the expertise available in our financial area to meet these challenges. Again, at some point in time this may become difficult to support on our present bed base.

4. *HMO market.*—The hospital's attractiveness in capturing the HMO market is based primarily on the relative cost of its services and its accessibility to HMO members. We have been most fortunate up to now in being able to remain competitive as far as costs are concerned. In the area of *accessibility*, there is no question that the horizontally dispersed multiinstitutional systems which emphasize primary care have an advantage, provided their rates are competitive.

In our area, HMO development began about 1973, and now 20 percent of our population is covered by HMOs. The U.S. Department of Health and Human Services (HHS) is in the process of developing a contract with certain HMOs to provide the HMO option to Medicare beneficiaries on a pilot basis. We are paying close attention to this process, because if this should happen in our area, the HMOs could capture about 50 percent of the market.

After we assessed our strengths and weaknesses, we asked ourselves what will happen in the years ahead to the quality of our program if we did nothing. The obvious answer was that while we could probably survive in the short term, our strength would gradually be eroded until we were no longer able to support our programs and we would no longer be the hospital we had decided we wanted to be.

Since this was an unsatisfactory outlook, we asked

ourselves what we could do to strengthen our base. For us, several very significant courses of action became obvious immediately.

1. Even though we are a referral hospital with a number of very strong tertiary services, we recognize that referrals are fickle and that our basic strength must be built by cultivating and increasing our penetration of our service area. We have raised our image through community programs and an aggressive public affairs effort in our natural service area.

2. We decided it was important to build our own physician referral base by recruiting primary-care physicians to practice in our service area.

3. There was a number of areas in which we had built management and clinical strengths over the years in our hospital. In order to broaden our financial base and thereby maintain and increase the level of expertise in these areas, we decided to market these services aggressively. I am talking about such things as our management engineering program, inservice and patient education programs, computerized tumor registry, and laboratory services.

4. We organized a foundation and are embarked on an aggressive fund-raising program.

5. We are beginning to develop management contracts with hospitals in our service area and are also directing our marketing efforts for the services in 3 above to those hospitals which do not need management contracts. While these activities provide additional sources of revenue, our primary targets are institutions and communities that have the promise of strengthening existing medical referral patterns or building new ones.

6. We have developed vertical linkages with home nursing services and nursing homes.

7. We are building on our clinical strength in cancer treatment, emergency services, rehabilitation medicine, and so forth to broaden our referral base.

Even after having directed a major effort to strengthening our organization internally, we are still open to the development of linkages with other hospitals. We feel that it is necessary for any single-institution corporation to keep an open mind on linkage. We think it is important not to panic and to carefully analyze the opportunities that present themselves. In our situation a meaningful linkage with other institutions may well be required in the future if we are to achieve the objectives we have established for our hospital.

The problem lies in determining what type of linkage

and with whom. We have been deeply involved in shared services, computers, laundry, and so forth. Frankly, we have almost exhausted the advantages of this type of relationship. We think we have explored all models of linkage from the loose association to merger. At the present time we are in merger discussions with another significant hospital in our community. Consortia and other linkage models that do not require the ultimate marriage characterized by merger are often unwieldy and uncontrollable. Unfortunately, we have noted that they often just add another level of bureaucracy without really improving operational effectiveness.

On the other hand, the mergers we have witnessed in our area have been extremely traumatic. They have resulted in dislocation of medical staff and key personnel. As yet, there is no evidence that they have made a contribution to economic effectiveness. They certainly have not reduced costs. Some of their proponents indicate that after the organizational trauma has subsided, they will be better able to contain costs than the traditional hospital owing to the increased volume of activity and greater depth in management expertise. This may be true, but it remains to be clearly demonstrated.

From observations I have made in our area, it would appear that mergers do have the potential to provide greater strength and depth in management, and there is little dispute about the fact that they have caught the imagination of the planners and enjoy considerable political clout. It appears to me that the main advantage of merger over consortia and some of the other more loosely organized models is that for better or worse, it

does assure irrevocable commitment.¹

In summary, I would say that, if what is meant by the *traditional hospital* is a single-hospital corporation, I think its future depends on realistically determining the type of hospital it wants to and should be. This determination must be supported by a realistic assessment of its strengths and weaknesses to determine if it can, in fact, achieve these objectives. After settling this issue, the next step should be to do everything possible within its resources to strengthen its base, through increasing its productivity and bolstering its position in its service area by whatever means possible, including marketing those services in which it has or can develop strengths.

Having done this, the single hospital must remain open minded to the possible necessity of developing linkages with other institutions to broaden its base. The questions are, Linkage with whom, and what kind of linkage? This will depend on the requirements of each individual situation. Shared services and consortia lack commitment for effective and expedient action. They can, however, be abandoned if they prove unsatisfactory. Mergers, on the other hand, require a final and total commitment. For this reason, perceived potential benefits must be thoroughly and realistically analyzed. Do not panic. Timing is important. The best time to explore linkage is when the traditional hospital is still dealing from a position of strength. For a hospital to wait until its viability is being visibly eroded before it explores linkage is to invite disaster and surrender in the negotiating process.

¹Many articles on the subject of merger are merely show-and-tell descriptions which lack depth and useful analysis of this complex process. Some of the most helpful information I have found on the topic has been provided by David Starkweather. In particular, I refer you to his article on mergers in *Multihospital Systems: Strategies for Organization and Management*, ed. Montague Brown and Barbara McCool (Germantown, Md: Aspen Systems Corp., 1979). There is more substance and realistic information on this subject in this brief, thirteen-page chapter than in anything I have previously read on the subject.

General Discussion

RICHARD W. FOSTER, CHAIRMAN

CHAIRMAN RICHARD W. FOSTER: Earl, you mentioned that you are the primary hospital for one of the HMOs in your area; I presume that is the St. Louis Park group. How much of your hospital business comes from the St. Louis Park group?

EARL G. DRESSER: About 47 percent of our total inpatient admissions come from that group, and about 12 percent of those admissions are HMO.

CHAIRMAN FOSTER: It seemed to me that, in terms of your concern about referral base, they certainly must be working in the same direction.

MR. DRESSER: That's true, they definitely are, and they have their own recruitment program and are establishing satellite clinics. But we are of a size and a level of medical sophistication such that the people who are contributing the other 53 percent of our business are extremely important to us, and so our activities in physician recruitment are not only to be helpful to the clinic but to provide a referral base for the independent and small-group-practice physician.

Actually, our efforts have been more in that direction. We have a situation in which in a real sense we have two medical staffs rather than one, because I think you can imagine the political dynamics of having your activities split by two competitive groups. We have always indicated to both groups that we cannot deliver the quality or the level of service that both of them demand with only half a loaf. So, while the clinic is operating on its own, we also have to support the activities of the independent physicians.

CHAIRMAN FOSTER: Since you mentioned that you were recruiting primary physicians for the local area, I would anticipate that you might encounter some resistance on the part of the St. Louis Park group to your recruitment of primary physicians for the same area in direct competition with what they are trying to do.

MR. DRESSER: We do; it's a trade-off. They get some of the good apples in the basket and other people must get some of the good apples.

RICHARD L. JOHNSON: Earl, looking back over the development of HMOs in your area, if you had your druthers, would you have preferred to have been involved in the formation and have a seat at the board

table, or would you prefer to stay as you are now, where you are simply contracting with them?

MR. DRESSER: Hindsight is just excellent, Dick, and I can answer you on that basis. If we were able to get proper representation on that board, there is no question about the fact that we would like to be in. But when we were invited, we were offered one seat on a ten-member board. That was not very attractive to us.

TIM SIZE: When you were talking about the internal factors you considered, you made quite a point about concern for the amount of management time that was available, particularly given increased external resources, and you mentioned some initiative in the area of management contracts, management services. I was interested in those conflicting directions, the stresses they put on your management team, and how you handle them.

MR. DRESSER: That is one of our challenges. I'm not sure that we *are* handling them. We're a little thin in this area, particularly as we reach out, and we're going to have to augment our staff. My hope is that by building a broader base and selling some of these services, I can build a revenue base to support more depth on our management staff. . . . I do not know if I have addressed your question.

MR. SIZE: Perhaps that was a question with more than one answer. On one hand, your base hospital's needs are growing; at the same time, to meet those needs you are pushing your management staff to do additional work. What happens in terms of the department head levels? You are pushing them to get out and work for other hospitals at the same time that their own jobs are becoming more complex.

MR. DRESSER: Let me cite an example, in one particular area, that might illustrate what we are trying to do. Management or industrial engineering has been a part of our overall program for over ten years. We have developed quite a sophisticated staff in this particular area. It would be impossible for us to support that level of sophistication on our current bed base if we were not selling services, but because we are selling the services to other hospitals, are generating revenue and have been able to be quite effective in recruiting people to our staff

and maintaining staff expertise. I think that one of the purposes in selling services is to do this in a number of areas, and I think that this is one of the things that Bob Montgomery was getting at yesterday. If we can broaden our base to support these management services by selling the service outside the walls of the hospital, and we think we can, this is the way we are attacking the problem.

MR. WEBB: On that upgrading of the CAT scanner—how likely would you be to take that issue to the public in your primary service care area and try to gain support for that?

MR. DRESSER: Very likely. Another thing that should be done in the primary service area is to cultivate it as a political power base. We think the numbers are arbitrary because we have a very active emergency service and a very active cancer program which require that tool. To make the sole decision on the basis of an arbitrary numerical guideline with all of the spin-off there is to this diagnostic tool—I think we would not be discharging our stewardship if we didn't make a scrap out of that.

MR. WEBB: It seems to me that nine times out of ten, when push comes to shove, the institutions are not taking that to the constituency, whether it's through newspapers or publications. And you are relatively isolated.

MR. DRESSER: We are not that isolated; you know the geography of the area. We identify with a group of suburban communities and overlap with other hospitals; we're by no means a single hospital, nor are we in a single-hospital community.

Going to the newspapers, of course, would only fan the fire and plead the argument to the HSA. Representation on the HSA is geographical, and, as my colleagues in the Twin Cities area can tell you, there is a political ball game going on with this HSA, with constituents who can be influenced. So I'm talking not about a great deal of publicity but about getting to the opinion makers who can make things move in the political environment. Some of my colleagues in the Twin Cities area represent institutions that have done exactly that, and we have done it, too, and that is the way the ball game is played.

MR. WEBB: Up to now, that's the way it has been played. I do not think the public is dumb, and I think that they can be won. In a good many cases health care systems do not go to them at all.

MR. DRESSER: I would not argue with that; I was responding to the matter of using newspapers as vehicles of influence. They have not been such vehicles for us.

LEON C. PULLEN: Earl, I would like to bring you back to the subject of your talk, "The Future of the Traditional Hospital." My first question is, what do you think the future of the traditional hospital is in relationship to all the subjects you were just talking about?

MR. DRESSER: I think that, here again, it is situational. In a metropolitan area like ours, if you are of a reasonably economic size, the route you ought to take is to strengthen yourself internally, unless there are some compelling reasons to enter into a merger.

Quite frankly, I really have very little sympathy for trying the consortium approach or anything else like that. I think that for the individual hospital it is a matter of *either* doing the best possible job to sharpen your own operation and maintain your program on that level, *or* merging with somebody else. I do not think there is an in between. There are some hospitals which can do that, depending on their size, their ability to manage, and so forth, and some cannot. I do not know where we are right now, to be totally honest with you; that's why we are exploring linkage.

RONALD ANDERSEN: You mentioned that about half of your referrals come from the HMO; is it possible, then, that in any given year, you could lose, as contract time comes up, half of your inpatients? I think of HMO association with hospitals as a way to stabilize referrals of inpatient admission.

MR. DRESSER: First of all, I misspoke if I said that 50 percent of our activity comes from HMO. Almost 50 percent of it comes from the clinic group that sponsors the HMO, but only about 12 percent of our business is HMO. Whether it is 12 percent or 50 percent, the question you raise is very relevant.

Yes, quite frankly, you could lose it. All of us in the Twin Cities area are aware of the fact that the decisions are now being made on those two bases—cost and accessibility—and will be made increasingly on these bases as the market is penetrated more by HMOs. In order for the HMO to compete in the market and to sell its coverage, it needs a competitive per capita rate. The way to do that is to buy their inpatient care at the lowest possible price, because the last thing on which they

would economize is the outpatient side of the business since that's their own pocket.

MR. ANDERSEN: This generally means a more volatile situation for the independent hospital.

MR. DRESSER: I think it is a more volatile situation for anybody. However, I indicated that the horizontally organized multiinstitutional systems with institutions in a number of different HMO markets probably have—or could have—a little leg up on the basis of accessibility.

But you are absolutely right, because the HMOs are changing referral patterns all over the lot, and they are changing the concept of conventional primary service area. We are getting patients through the HMO operation who are totally outside our natural service area. After that develops for a while, the hospital that naturally serves that particular area is going to become as competitive as they know how to be in order to keep that business at home.

THOMAS CLARK: I agree with the general feeling that a thirty-two-member board is too big, but trying to shift members of the board out is almost as difficult as trying to close hospital beds. What strategy do you have to reduce that board of governors to a manageable size?

MR. DRESSER: That's a good question, and it really hits home, because despite a great deal of discussion, we do not have a strategy.

So I do not have any easy answer to that; I guess attrition is about the only way to reduce the board. And not all of the leaders of our board concur with my point of view, which is the point of view of people who have been through the chairman's position and have had the responsibility for making the board work. I work with them, of course, all the time, so I have long been sensitive to this problem.

PETER SAMMOND: We're going to do it through merger and then have an eighty-two-person board at the hospital

MR. DRESSER: We do have a merged corporation that has a seventy-five-member board, and I do not know how that works.

ODIN ANDERSON: How do you keep track of what is happening to you? For example, you said that the referral patterns are changing. Do you use payment sources and billings and so on?

MR. DRESSER: Yes, and patient origin studies. One thing that we really regret is that, when we suddenly became involved in this HMO business, we didn't col-

lect baseline data. We would have a much better management tool today if we had had a good data base.

CHAIRMAN FOSTER: Listening to you, I felt that you were not at all confident of the future of the traditional hospital, particularly in the area of developing referral sources. Do you feel threatened by the growth of the HMOs in the area? Do you think that they will essentially close off your possibilities for other referral sources, that they will be the point of access and will have institutionalized referrals that leave you out?

MR. DRESSER: I don't know. We have some general concern on the development of a financial strategy to bid with the HMOs. While I indicated that the HMO with which we do business could be attracted by somebody else for those patients they are drawing out of the other hospital service area, it is also true that there are HMOs with which we do not have a contract and which have patients in our service area, and we can contract with them. So that saw cuts both ways.

I did not mean to sound pessimistic about the viability of the individual hospital, because I am not really that pessimistic. I tried to be realistic about it, and I want to stress the fact that I think it is situational. I have a colleague who runs a hospital the same size as ours in a Minnesota community that's a one-hospital town. The last thing in the world he needs to worry about is getting involved in a multiinstitutional system, as far as I'm concerned.

CHAIRMAN FOSTER: I gather from your answer that you think that it is practical for a single hospital to be hospitalizing patients from a variety of HMOs?

MR. DRESSER: I think so, and it's being done. Paul Olmstead represents an organization that has got a contract with about three HMOs.

PAUL OLMSTEAD: We have one with two. The predominant one is the one I mentioned, but we have one other, and that is really the way you defend yourself.

MR. JOHNSON: I would like to make an observation. The number of hospitals in Syracuse, New York, dropped from eleven to five; now all of them are running 85, 88 percent occupancy. This ties into what Ron was saying a minute ago: If you can get into a tight bed situation, you have less fear of contracts being shifted because there is no place for them to go. So that would dictate, would it not, a strategy of saying, "Yes, we're in favor of closing those 2,000 excess beds" (or whatever number you have in your area) in order to prevent the HMO from exercising that option?

MR. DRESSER: I agree with your observations. And it may come as a surprise to a couple of my colleagues here, but we have talked about that at the executive committee of our board many times, namely, that one of the healthiest things that could happen to all of us would be to cut those 2,000 beds out and let hospitals start to get a bit of control over the system again.

MR. ANDERSEN: Would you be willing to have a proportion cut from your hospital?

MR. DRESSER: You asked the inevitable question and I can say, yes, because there are a few we must cut.

Summary Discussion

RICHARD W. FOSTER, CHAIRMAN

CHAIRMAN RICHARD W. FOSTER: May we reconvene, please? This is probably the "everything you wanted to know but never had anybody to ask" part of the show, for we have some people up here for you to question. Also, if any of you want to make comments or observations on the program thus far, you will have an opportunity to do so.

We have several of the symposium speakers here, and we have an additional panelist: Marc Voyvodich is a program officer with the Robert Wood Johnson Foundation, and prior to that he was assistant to Walter McNerny at the Blue Cross Association. Let's start with Marc.

MARC VOYVODICH: It has been fun and instructive for me to sit in on and participate in this symposium on hospital affairs. I am soon going to leave the Robert Wood Johnson Foundation for Portland, Maine, to organize and develop a hospital consortium that will be working to build both horizontally and vertically integrated arrangements. This symposium has given me a lot of new ideas on how to approach the job—not to mention some new anxieties about what I'm getting myself into.

I am going to try to summarize what has transpired here in the last ten hours or so of symposium proceedings, and then I will make a few editorial comments. After that, Richard is going to moderate a summary discussion.

Uwe Reinhardt began the symposium with an economist's perspective on the kind of environment that has shaped and will continue to shape the operations and growth of health care services. He plotted a set of economic achievements of the 1970s which made possible a health care resources' growth rate averaging nearly 5 percent per capita per year in real terms, which is substantial.

But economics being the dismal science it is, this report was quickly followed by the familiar litany of bad news: energy costs rising ten-fold in the last decade, inflation becoming a way of life and threatening the very moral fabric of the nation, and productivity falling to a point where countries such as Japan and the Netherlands are growing 70 percent faster than the United States in terms of productivity. Uwe concluded that it is pretty difficult to be bullish in the 1980s with growth of the economic pie nearly stalled; gains in one sector of the economy can only

come at the expense of another. Replacement of capital stock, defense spending, and federal debt retirement will be just a few of many worthy competitors, along with health care, for the dollars available in the 1980s. He assumed that growth will continue in the health sector but will be much slower than we have been accustomed to in the last decade—probably somewhere around 1 percent per year in real terms.

According to Uwe, the fight for a share of the health care income could change the health services landscape fairly significantly in the 1980s. For example, quasi-markets might develop, such as those that have evolved in Europe, in which interest groups participate in fairly free-wheeling negotiations to develop economic guidelines for the health care system. In addition, physicians might try to retain a greater percentage of the health care dollar. We might also see rationing, which in the past has occurred mostly as a result of inadequate supply, in the form of rationing by budget; in fact, this is already beginning to occur.

Uwe ended his comments like a typical economist, saying, "I could be wrong."

Odin Anderson gave us the health services version of *Roots*. He traced the growth of hospitals and the social and political dynamics which have catalyzed that growth through three periods in the last century. In the first period the health services infrastructure developed; in the second, third parties and fringe benefits came on the scene; and, finally, in this, the third period, Medicare and Medicaid made their appearance.

Odin went on to predict that the field is slowly evolving from a rather riotous pluralism toward a more structured system, in which managers will have a more important role to play than they have had in the past. Then with the bravado sparked by his accurate prediction seventeen years ago that health services would be consuming 9 percent of the GNP in 1980, he optimistically predicted that health services would be consuming 12 percent of the GNP in 1988. And he concluded by saying, "I could be wrong."

Rich Foster spoke about how the failure of the health services market forces has promoted regulation and how, in turn, the failure of regulation is now promoting efforts to stimulate market forces.

So much for my Cliff's Notes on what has transpired in the last ten hours or so. Let me close with just two editorial comments—which I must admit have changed somewhat after my discussion with Odin this morning, when he told me that one of the intents of this program was to make sure that an upbeat message was put forth.

First, vertical integration is certainly going to be a difficult, demanding management challenge for hospitals in the future. It may not necessarily require new management skills, but it is going to put additional demands on the traditional skills. The most exciting thing about integration, in my mind, is the potential it holds for providing significantly more management flexibility in the future.

There is a caveat that has to be attached to that, namely, in order to realize this flexibility, it will be essential that changes occur in the reimbursement structure. Vertical integration does imply that individual hospitals could, in many instances, evolve into what could be considered microcosms of a total health delivery system, including preventive, primary, acute, tertiary, and post-acute care. The best way to allocate resources within these delivery system microcosms, if you will, is to have the flexibility to make those management investment decisions outside the fairly narrow constraints that exist within our current reimbursement arrangements.

In other words, the status quo will probably have to be changed if these new organizational entities are to flourish in the long run. I am not exactly sure what that implies; perhaps hospital capitation payment systems. Regional maxicap of resource allocation models or other more innovative and inflexible methods need to be developed for the new organizational arrangements. It took fifty years to build the current reimbursement system, and I suspect that it will take another fifty years to build a new and more appropriate one for these evolving organizational structures. I would encourage you all to make sure it does happen, because otherwise the new organizational structures are not necessarily going to reduce the constraints under which you are working.

Finally, it's clear that we have had trouble during the last two and a half days defining "vertically integrated health services." There just do not seem to be any consistent models or approaches that are self-evident. I have not found a pat, usable definition at this symposium, but I don't find that too worrisome. We have a

tradition of pluralism in the evolutionary development of health services in this country, and that has basically been a product of pragmatism—the practical search for workable and affordable solutions in a local community environment.

No two communities have the same health service needs and demands. No two have the same historical configuration of resources or the same funding mixes or the same leadership structures. Solutions to health delivery problems should and do look different from place to place, and this needs to be so if the most effective job is to be done. So I believe that even as vertically integrated systems proliferate and mature, which they almost certainly will, in various areas of this country, confusion will remain about how they are appropriately defined, what they should look like, and how they should go about serving their community. But I could be wrong.

However, I am confident that this has been a superb symposium, and I congratulate you all on a fine job. Thank you.

CHAIRMAN FOSTER: Thank you, Marc. Before we have questions and observations from the floor, I want to give the other panelists a chance to add their comments, if they have any.

ODIN ANDERSON: I want to qualify my remarks about being wrong by quoting the late Dr. Ezelstone, founder of the Rip Van Winkle Foundation on the Hudson and a very prominent person in the prepayment, HMO movement, who frequently said, "I may be wrong but I have no doubts."

And I will hang onto that 12 percent no matter what. That does not mean that the hospitals would necessarily stay at 40 percent or even increase. But I think the nursing homes are going to get a bigger portion, not to mention the hospices, because everyone has to die. Given the momentum and the aging population, I see greater expenditure, with a different mix.

CHAIRMAN FOSTER: Let me take one shot at confusing people further about the nature of vertical integration. Vertical integration pretty much follows the path of the patient, and it is useful to think of it on a continuum. At one end you might have a hospice and at the other end something like a wellness program, to encourage people to jog around the lake and that sort of thing. Along this continuum there is a range of services that we would characterize loosely as the traditional hospital.

Marc stimulated part of my thinking on this with a

discussion yesterday about the traditional hospital as a vertical system, in the sense of having intensive care units, outpatient clinics, and so forth. Much of the discussion here is a question of whether these boundaries should shift a little bit more one way or another. There does not seem to be much consensus about that. Don Oder, I think, went further than almost anybody else in terms of how much of the range should be in one area, although Bob Montgomery got pretty far along the continuum as well.

However, the vertical system need not necessarily be an expansion around the traditional hospital. A vertical system need not even involve a traditional hospital. A small-scale example would be a group practice that operated its own laboratory facilities. You could take that model and expand it in the other direction and get something, for example, Kaiser-Permanente, that would overlap with the traditional hospital.

I wonder whether it is possible to say much at a general level about what the right range of services is or whether it depends more on the specific services. We must be more specific about particular services in order to determine if it is appropriate to have them in one organization.

One other comment: I think that there is another kind of vertical integration that is actually closer to the model in other industries and that has to do with essentially the make-or-buy decision that a hospital makes about inputs to the patient care process. It seems to me that there the trend is clearly one of vertical disintegration. The Rush system notwithstanding, nursing education is a good example: Hospitals certainly used to be very actively involved in that and are much less involved today. There are more shared services, which can be seen as vertical disintegration. The increased contracting of services for departments and the use of management consultants may be viewed as examples of the organization going to the outside for services that traditionally may have been produced inhouse.

But the trend in this direction, in which everyone is thinking of further integration, is so dramatically different from that, that I wonder what it is about the patient flow or perhaps the physicians that characterizes this dimension. A number of people have pointed to the significance of the role of the physician, but I think we have a lot more to understand about that. I was particularly struck by Bob Brueck's comment yesterday that he felt that further integration along these lines was

contrary to the interests of the individual physicians. And I would like to ask Bob if he would elaborate on how this integration conflicts with the interests of the individual physician.

ROBERT F. BRUECK: Over a period of years we have seen physicians voluntarily organize themselves into group practices, primarily single-practice groups. Many of them are interested in developing programs that might lead to HMOs, but it seems to me that a single-practice group is one that lends itself better to a horizontal structure than to a vertical one, and physicians have particular interests they want to maintain as opposed to trying to expand their activities to a whole range of things.

Perhaps if you had enough of these horizontal physician groups put together, you could work them into a vertical structure. However, it seems to me that physicians are exposed to less financial control than are hospitals, and I think that physicians will continue to be interested in the kinds of dollars that they can generate. And if they can do this by doing more business outside of the institutional structure, I think that is what they are going to want to do.

On the other hand, there are going to be more physicians, and I think that more and more of them will be interested in employment or some other kind of relationship. So, although I am uncertain about this, I don't expect physicians to move voluntarily into any kind of a vertical situation.

CHAIRMAN FOSTER: If we look at it in terms of controlled and uncontrolled segments of the health care system, the physicians are much less controlled than, say, hospitals and nursing homes. You seem to be painting a picture of a vertical system as an intermediate animal that looks very attractive to the hospitals because they are very strictly controlled. But why would physicians go to an intermediate position from an uncontrolled position?

MR. BRUECK: They are going to be exposed more and more to some kinds of controls, and I think they are trying to seek their best position.

CHAIRMAN FOSTER: Physicians may put their economic interests ahead of their professional interests.

MR. BRUECK: That's what frequently happens. And I suppose that is the kind of message that I am trying to give.

PETER SAMMOND: Can you make vertical integration work unless you and the dominant group of physicians with whom you deal have common interests? It seems that is what Bob Montgomery has done by including them in his system's governance and planning process, even to the point where they have made some sacrifices to make the institution and the integration work. Are there any examples of effective integration *without* the system and the physicians sharing interests?

MR. VOYVODICH: I think you are absolutely right. Bob Montgomery really hammered home the point yesterday that physicians will, in fact, take a very business-like, pecuniary approach to decision making in terms of how they are going to practice and to make referrals. Most of the battle consists of showing that the physicians' participation in the activities that you are planning and evolving toward in terms of integrated systems is within their enlightened self-interest. His example of the sports medicine clinic is eloquent testimony to that fact: Until the physicians found what was in it for them, they really were not very interested in the idea.

CHAIRMAN FOSTER: There must be more to it than just involving the physicians in the decision-making process. If Bob is right that, to a significant extent, the physicians' interests really do not coincide with the vertical system, I do not see how involving physicians in decision making is going to push you toward a vertical system. The wellness program may be a good example of one particular kind of vertical program that you can sell to the physicians, but there must be something to sell.

RICHARD JOHNSON: I am not sure I agree with Bob. If you look at the development of HCA and the physician's position in all of this, you see that the physician has remained important at the local institutional level. However, there is a whole big structure beyond him about which he knows relatively little and cares even less, as long as it remains economically neutral with respect to his interests. And I think we are going down the wrong road if we think that the physician is important in this kind of thing, although he is terribly important in dealing with the patient.

MR. BRUECK: We also ought to keep in mind that when we are talking about a vertical system, we are talking about a patient-flow problem, and one of the things associated with patient flow has to be the referral pattern adopted by the physicians. You do not legislate referral patterns, you do not try to tell physicians what

to do or how to do it. They develop these kinds of patterns on some very personal, and sometimes curious, bases. That is the kind of thing that I think you have to be concerned with in fitting the physician into a vertical structure. Now, we do not know enough about how these patterns are developed or what maintains them or anything else like that. If we are to have a viable vertical structure, we must recognize that physicians are going to play a prominent part, and we are not going to legislate what they are going to do or how they are going to do it. They will tell us how they are going to manage their affairs, and we will try to adapt to them.

MR. JOHNSON: How is that different from a retail store saying, "We have to please the customer"?

MR. BRUECK: Not different at all; very much the same.

ROBERT OSTROWSKI: One question that strikes me in all this talk about vertical integration is, What are the social implications for the community? All of a sudden you are developing a system which may, in fact, become the most powerful system in the community—power being defined as the ability to exert influence. Does this tend to generate hostility from other institutions in the surrounding area? How is that handled? For example, what if one health care system becomes the largest employer in the community and taps a labor pool which might have been available to other industries in this community?

MR. JOHNSON: There are very good examples in other industries of corporations that dominate a town, for example, Caterpillar in Peoria, Kellogg in Battle Creek. Typically, those corporations decide to keep a low profile in the community because they are afraid of exactly what you are talking about. They become very reticent about taking the lead on social problems for fear the community will believe it's a company town. Moreover, industrial leaders in a community avoid squeezing their local hospitals in an effort to control costs because they do not want reputations as the ogres in the town.

ROBERT KATZFEY: I think that is changing, too: Industry is taking a much stronger interest in squeezing the hospitals overtly as well as covertly. I think it is just a matter of time before the Caterpillars and the Kelloggs say, "If you guys aren't doing it on your own, we're going to have to do it, and we'll step out in front and do it." They will set up their own HMOs and manipulate the union to the extent that they can, to get benefit packages that will allow them to reduce the money that

goes for medical care. To be economical, they *must* do it.

MR. JOHNSON: In the long term, I think that will probably happen. In the last few months, I have had executives of large companies look at their annual budgets and say, "Well, the health care costs have really escalated and it's disturbing to me." When I ask the magnitude of the increase, they say, "We went up \$100,000 last year in our prepayment." But the cost went from 2.5 to 3 percent of the total budget, and that was not enough to make them want to get out front and lead that issue. If that had been a 20–25 percent portion of the budget, they would have considered it worth some executive time to assume that leadership. In short, I think that in many companies, the health-cost percentage is still so small that the executives are not yet ready to do something about it, although in time, as costs rise, they will.

MR. SAMMOND: Just to add to what Bob said: It is happening in our community now. Honeywell has taken the lead, they are stepping right out. I do not know how they are going to deal with the unions, but they are going to cut out benefits.

JOHN WITT: It seems to me that many large corporations are *adding* health care benefits when they negotiate with the unions. The health care benefit package is growing to include dental care and maternity benefits. The employers are not doing much to put the control of health costs where it belongs: on the original buyer and purchaser of that care, namely, the patient, who may be overusing the system. Employers keep giving people more and more benefits, but they are not the ones willing to take some of them, although they complain about costs.

CHAIRMAN FOSTER: Are you saying that employers are not willing to institute cost sharing on the part of the patient, but they are much more aggressive in trying to put pressure on providers to withhold the services that they guaranteed under their benefit package? And are you saying that is unfair?

MR. WITT: I just think that the health care system has to stop taking the blame from the executive who is giving away the benefits and then making it seem as if something is wrong with the people running the health care system.

CHARLES P. HALL: I believe that industry is starting to take a more firm position. Last month in Atlanta I attended the annual convention of Richardson Shared Management Society, a conglomerate of corporate

insurance buyers. If there was one single theme of the convention, it was that many large corporations and companies are now going to take a firm stand. They will insist on cost sharing at the patient level, participation in the early dollar. And some companies are taking firm stands on other issues, such as whether the entire union must take HMO health care rather than allowing some members to have HMO and others, some other health insurance. Other employers said that this has become the single major issue in most labor negotiations the last couple of years: Who is going to pay how much, for what kind of benefits? Many of the work stoppages in the last few years have been on that issue and that issue alone, and the big corporate buyers around the country have come to the point where they are ready to take the stand, as Honeywell has already done in Minneapolis. They will force the issue and say to the unions, in effect: You cannot have first dollar coverage for everything and at the same time get the ambulatory services that you want because the pie is finite; you have to make some choices.

MR. SAMMOND: John Witt is right; they are talking that way. But will they really carry through in the bargaining?

MR. WITT: I want to see them take a strike on that issue and win and get back what they have given. They have not had the backbone to do that yet.

WESTON D. BERGMAN: The significant thing is that it is the first time in twenty-five years they have even talked that tough. I think that means that something is going to break pretty soon. It is getting to the point where the cost of these benefits really hurts, and they cannot take it forever.

EVAN FREUND: I would like to pursue the question of the accountability of these vertical structures and the holding companies which would bind them together. What steps have been taken to anticipate the demand for public accountability, not to say political accountability, of these systems? With a fairly visible board of directors and an organizational structure manipulating the whole system, the structure may be perceived as doing just that and as controlling the system without public accountability.

CHAIRMAN FOSTER: One response to that is Don Oder's remark that a vertical system does not really work unless it is competing with other vertical systems, and vertical systems turn out to be a mechanism for

introducing this kind of competition. There is an accountability built into that, because if you do not provide what the consumers want, they can go someplace else that is not that difficult for them to identify and choose. If the organization of a vertical system is a means of monopolizing the market, you have a serious problem: How effective can these be in rural areas or other small areas?

MR. JOHNSON: Bob, given the unparalleled growth of the investor-owned systems during the 1970s, what do you foresee in terms of growth for that segment during the 1980s?

MR. BRUECK: I think the growth rate will be roughly the same. A fair part of the growth will come in the international market, and it will be slower developing and longer lasting. But there is still a lot of room for multifacility companies to grow.

CHAIRMAN FOSTER: There seems to be much less interest in integration on the part of the investor-owned systems, and Bob gave a number of reasons for skepticism yesterday. He said it was much easier for him to integrate horizontally. But it strikes me as an odd coincidence that the investor-owned systems and the voluntaries look at the same problem and come to such different conclusions. Bob seemed to be saying that, after they decided they needed 15 percent return on equity, they decided there was no way they could do that as an acute care hospital, so they went out and sought a number of other activities. I suspect that your reaction to that, Bob, instead of looking for new activities, would be to say, "If we can't generate 15 percent with this acute care hospital, it is a turkey, and we ought to get rid of it." Is that a fair assumption?

MR. BRUECK: I think that is a fair assumption. The kind of corporate structure we have must be concerned with maintaining its viability and growth. If we can maintain the kind of growth rate that we want, doing what we are doing and what we know best, there is not a great deal of incentive for us to change.

As you begin to look at the future of the hospital business, you have to say that somewhere down the road, you will probably change your way. The trick is judging when you need to consider some diversified activity. There is not much point in changing the successful pattern if you anticipate that it will continue to be successful for a while. That is one of the reasons we are not looking at other things.

Another very practical matter is that, when you look at the health care business as a business, there really are

not many things more profitable than hospitals, and there is not much point in getting into something that is less profitable just because you think it might be fun.

FRANK C. SUTTON: On the future of the traditional hospital: Should the future model for the mid-size and large hospitals be the independent, possibly with Sherwin Memel's holding company, or should it be multiinstitutional?

EARL G. DRESSER: I think I will let somebody else answer that because my basic premise was that what was required to maintain the viability of the traditional hospital is a single-hospital corporation. If you determine that you cannot maintain the viability of the individual institution as a single-hospital corporation, I do not think I am competent to determine whether it ought to be a single corporation merged with another institution or whether it ought to be a holding company. That is not much of an answer, but my whole focus has been attempting to keep the traditional hospital, whatever it is, alive and pursuing a meaningful program.

CHAIRMAN FOSTER: What do you think about the traditional hospital being absorbed by a larger system? Is that the survival or the demise of the individual hospital?

MR. DRESSER: It could be either, depending on the situation. If it is a geographically dispersed unit serving a specific population, and if the surviving corporation is going to let it remain intact to provide its service program, I think the essential elements of the organization are being maintained. If the result is either closing the institution to consolidate the assets or moving it to a different site, it has lost its autonomy and has been absorbed.

MR. BRUECK: I agree with that, and I guess it depends on the system. However, in our situation we view each hospital as an important element by itself and expect each hospital administrator to run his hospital as an independent and relatively autonomous entity. So an organization need not suffer just because it becomes a part of a multifacility system.

TIM SIZE: I disagree unless you are willing to admit that your governing board is not an essential element of the traditional hospital, because that certainly must be the element that is eliminated when you merge into a larger system.

MR. DRESSER: No, the governing board is an essential element, and although it cannot have complete autonomy in a merged corporation, some of its autonomy is maintained through the holding company

model. Through that mechanism you could preserve the majority of the contribution that the particular board is making.

One of the principal messages I have been trying to convey about the merging of single institutions is that, when an institution is considering merger, such a move must be and can be clearly evaluated. There may be situations in which it is important to develop a linkage; such a linkage must be formed when your institution can deal from the standpoint of strength. It is crucial to determine this and to avoid merger just because it is an "in" thing to be doing at the time.

I think that there are ways of maintaining the program of the one-hospital corporation, but this is a situational matter. Each one has to be approached on the basis of the features of the particular situation.

SAM FRIEDE: I think the key word that you used was "maintain," while the title of the symposium is "Management for Growth and Future Expansion." I have not heard anything that will allow for growth and future expansion of the traditional hospital. So far the talk has been about maintaining; however, if an institution would not want to grow and expand, we have to look at other angles, such as merger. Would you agree with that comment?

MR. DRESSER: I would qualify it. When I was talking about staying on the cutting edge of technology and developing the programs that were required in order to meet the legitimate health care needs of the service area of the individual institution, I was talking about growth; I was not talking about maintaining programs at their present level. I am saying that there are ways and means under many situations for hospitals to remain as single units and provide for that type of growth. In some situations it is an absolute impossibility, but not in all. However, I often hear that you cannot have growth, cannot have development, cannot remain abreast of what is going on in the health care system unless you become part of a multiinstitutional organization. I may be too much of a traditionalist, but I think an institution can grow and remain single.

PAUL A. HOFSTAD: I think the question is, What is "growth"? I agree with what Earl is saying. We always

think of growth as "more," more beds and hospitals, for instance. But that is not necessarily so. Growth can be understood from other perspectives, such as in terms of nontraditional programs. A growing hospital need not be continuously adding beds.

MR. DRESSER: The other thing to consider is the purpose of growth, which helps define it. We all have different purposes for growth, but I think they all relate to dollars and financial viability.

CHAIRMAN FOSTER: Earl, you joined the majority of the speakers in saying that you felt that ownership was the way to go, that affiliations, consortia, and so on did not have much of a future—you either go it alone or you go the whole distance. Do you think that something like a consortium can be a useful preliminary step toward going the whole distance?

MR. DRESSER: It is possible, but the longer you play with a consortium model, unless you find some way of building some very significant commitment to it, the more difficult it may be to move on to merger because you have started to learn about all the things that you do not like about the relationship with the other organizations, and it is too easy to back out of it.

If you move into the merger situation—and I am not suggesting that you do so hastily—you have a commitment. You must stick, you must work it out. You do not have to do that in a consortium, and I think that when you start to have trouble in the consortium model, it is too easy to pull back.

MR. JOHNSON: I want to support what Earl says. Every consortium I have seen has trouble because somebody does not have levers when you get down to the stickiest problems, such as, Who gets the open heart program? The consortium seems like a great idea as long as all I have to do is say Yes, but the minute the guy starts saying No to me, that is when I take a walk. I just do not buy consortiums.

CHAIRMAN FOSTER: I perceive that there are some people getting nervous about catching planes, and so I will take this opportunity to thank the panelists and all of you for coming. I hope to see you all again next year.

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