

**Multi-Hospital Systems and  
The General Hospital**

*Proceedings of the Twenty-fourth Annual  
George Bugbee Symposium on Hospital Affairs, May 1982*

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

The Twenty-fourth 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 20-21, 1982. 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-fourth 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, Ms. Roberta Arnold who edited these proceedings, and Ms. Joyce VanGrondelle who typed the manuscript.

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## INTRODUCTORY REMARKS

Ronald M. Andersen, Chairman

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The first session of the Twenty-fourth Annual George Bugbee Symposium on Hospital Affairs, sponsored by the Graduate Program in Hospital Administration and the Center for Health Administration Studies, Graduate School of Business, The University of Chicago, convened at 8:50 A.M. Thursday, May 20, 1982, in the Assembly Room of the Center for Continuing Education, with Ronald M. Andersen presiding as chairman.

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CHAIRMAN RONALD M. ANDERSEN: Welcome to the Twenty-fourth Annual George Bugbee Symposium on Hospital Affairs. This symposium is directed toward the alumni, friends, and colleagues of the Graduate Program in Hospital Administration and the Center for Health Administration Studies. The symposium is planned by the Council of the Alumni Association, whose president this year is Ed Howe, and the program's faculty, and it is under the direction of Odin Anderson. I think you will agree that Odin has done a fine job in putting together this year's program and has selected very good speakers.

The purpose of our symposium is to address a significant issue in the organization and management of health services. This year's issue is multihospital systems. Some feel that an understanding of the development of multihospital systems is crucial for our development of strategies for survival and growth in health services organization. In the course of the symposium, we will consider what multihospital systems are, how they developed, how successful they have been, and what their future might be. We will be presented with several examples of different types of multihospital systems; in considering these examples and deciding which, if any, are right for you, remember that results can differ considerably depending on who you are and where you are located.

## THE STATUS OF FEDERAL-STATE POLICY ON REIMBURSEMENT

C. Thomas Smith

CHAIRMAN RONALD M. ANDERSEN: Our first speaker today is Tom Smith, president of Yale-New Haven Hospital. He has had a rich and varied career in hospital administration. He was vice president and executive director of Henry Ford Hospital, and he is an alumnus of the Graduate Program in Hospital Administration (1962). Of particular note for the purpose of our symposium today is Tom's position as a member of the Council on Federal Relations of the American Hospital Association.

Organizational strategies are greatly influenced by current and expected governmental policies on reimbursement, and so Tom's discussion of "The Status of Federal-State Policy on Reimbursement" is especially appropriate.

MR. C. THOMAS SMITH: Since our topic today deals with government policy, I think we should bear in mind the milieu in which such policy is forged. With the president's proposal to shift federal programs to the states, it is instructive to review the level of consideration which our programs are likely to receive.

A recent Wall Street Journal article reported on the output of some of the finest legislative minds in Michigan. Each of the following statements was made by a different elected official in a public forum and is now mounted for all to see in the Michigan State Capital pressroom. The first reveals the mutual respect legislators have one for another: "The Chair would wish the members would refrain from talking about the intellectual levels of other members. That always leads to problems." The next quote speaks to the likely effectiveness of our association lobbying efforts. All of us have been involved with AHA and our state association visits to Washington, and we often wonder what outcome that will produce. These two quotes speak to that. "Some of our friends wanted it in the bill, some of our friends wanted it out of the bill, and Jerry and I are going to stick with our friends." And another on lobbying: "I don't think people appreciate how difficult it is to be a pawn of labor." However, when it comes time to take a stand, you know that you can count on people like this: "It's a step in the right direction, it's the answer, and it's constitutional, which is even better." Followed by my favorite: "There comes a time to put principle aside and do what's right." And to confirm your faith in the system and to give you hope for support of health services, I like this one: "I don't see anything wrong with saving human life. That would be good politics, even for us." One last quote is appropriate to this occasion: "Before I give you the benefit of my remarks, I'd like to know what we're talking about."

Certainly no one in the health sector would ever be guilty of making such comments because we always know what we are talking about. Unfortunately, and too often, not everyone else does, and that is part of the task before us.

Regardless of our role in the health system, we are all faced with pervasive public concern about costs. Health care cost escalation is a major national issue, with costs in this sector of the economy consistently increasing faster than the Consumer Price Index. In 1981, the health component of the CPI increased at twice the rate of the general index.

While extreme cost escalation is of sufficient import to attract public scrutiny, such attention is even more sharply focused because of the major financing role of both federal and state governments. The combination of Medicare and Medicaid covers more than one-third of the population, with some hospitals receiving more than two-thirds of their income from these government programs. At current growth rates, Alain Enthoven calculates that Medicare will double its share of the Gross National Product every ten years and Medicaid every eighteen years. Added to all of this is a recessionary economy which poses hard choices for governmental policymakers and legislative bodies. Health services support is now a major competitor for a large share of our national resources. Health services consume 10 percent of the GNP, a proportion which continues to increase and naturally attracts attention.

Fifty years ago, our predecessors no doubt had a similarly complex agenda with which to cope. Hospitals in the 1930s had to worry about delivering service with a less sophisticated medical armamentarium, little or no third-party financing (private or public), modest facilities by current standards, far fewer health professionals, and a public wary of their effectiveness. We can all agree that tremendous progress has been made in this past half-century. The difficulties that were most vexing then have generally been overcome, some with broad public acclaim. The public now has a high, indeed at times too high, expectation of our effectiveness. As a result of committed professionals, the general elevation of standards of practice is remarkable, but it is now taken for granted. Our industry has been so successful that it has gained an ever larger proportion of our nation's resources to support our efforts. One consequence of this larger resource commitment, however, is the very broad and in-depth discussion now underway about the efficiency of the health care delivery system.

Given that effectiveness measures the achievement of objectives, there seems to be general satisfaction with the effectiveness of health services in this country. A New York Times survey in March 1982 found three-quarters of respondents expressing confidence in their doctors, hospitals, and health insurance. While there is much to be done, especially in increasing awareness of the impact of life-style on health,

considerable progress has been made in extending life expectancy and improving its quality. For example: Between 1940 and 1980, life expectancy increased from 62.9 to 73.6 years. Maternal mortality improved measurably from 1960 to 1980, with the number of deaths per 100,000 live births decreasing from 37.1 to 6.9. Infant mortality also improved markedly between 1960 and 1980, dropping from twenty-six to 12.5 deaths per 1,000 live births. Since 1968, death rates from ten of the fifteen leading causes of death have declined. Several types of cancer, which in the past had very poor prognoses, are today being cured because of improved diagnosis and treatment. Finally, patients with Hodgkins disease had little hope ten years ago, but today five-year survival rates for early cases have increased from 68 to 90 percent, and for advanced cases from 10 to 70 percent.

At issue, however, is our efficiency. That is, is our resource consumption compatible with our achievement? Could we do almost as much with a little less? If so, what do we give up for a given reduction in resources? While the public has confidence that our services are of a high caliber, it is questioning whether our management skills have kept pace. The issue takes on added importance with increasing competition for scarce resources. The concept of scarce resources is not a new one. It was clearly one of those tough issues that faced hospitals fifty years ago, and it has always been an important consideration. At the institutional level, given the talent and creativity of health care professionals, there are always more good ideas for support than there is support available. Balancing has always been a challenge, but it takes on new dimensions in the current environment.

Out of zeal to improve service and quality, knowing that such improvement was always for the patient's benefit, we have made huge resource commitments in every hospital in America. A major stimulus to high-quality service, other than personal and institutional commitments, has been federal government policy. A variety of federal programs have been developed over the past three decades for socially desirable purposes. All have been aimed at increasing our knowledge and assuring that everyone has access to services. As a result of providing access to knowledge and services, federal policies created the current environment. I cite a few specifics:

In the 1950s, the federal government began a massive investment in biomedical research via the National Institutes of Health, a commitment to understanding which has yielded impressive dividends. It also became federal policy to build hospitals throughout the country, financing new construction through the Hill-Burton Program in communities which did not even have a physician but had hopes of attracting one. With more hospitals providing more services to more people, health insurance coverage was expanded to finance these new expenditure opportunities.

The 1960s witnessed some payoff from our research investment. New technology began to foster new services. The desire to assure the broadest possible dissemination of this knowledge and technology led to the federally financed Regional Medical Program aimed at assuring that all hospitals had access to the latest technology. Additional service capacity generated needs for more health manpower to deliver these services, and again the federal government financed more and larger schools for physicians, nurses, and other health professionals. More system capacity also highlighted the inability of the elderly and poor to secure services on an equal footing with other segments of society, so Medicare and Medicaid were created to enfranchise financially this portion of our population.

In the 1970s, emphasis was placed on enhancing system performance, with key objectives being accessibility, continuity, and comprehensiveness. "Health care as a right" became a rallying cry to garner means for all citizens to have access to services. Governments accepted the obligation to deliver on this proclaimed "right" and thus become increasingly involved, not only in financing but also in planning health services. The first major public efforts to control the health system were in the form of approving capital expenditures and major program changes via the federally created Comprehensive Health Planning agencies.

In summary, the federal government has sponsored expansion of knowledge, technology, institutions, services, manpower, and finances, and it assumed responsibility for assuring accessibility to all segments of society. Thus it should not be surprising to anyone that the share of the GNP consumed by health services has tripled in the last half century. Public policy initiatives created programs and provided the financing which produced this outcome.

That brings us to the 1980s. We hear very little these days about expanding services. The current scene derives its momentum from concern about costs. Governments have consistently paid hospitals less than full costs and are now threatening to pay even less. Questions are being raised about which services are essential and which merely desirable. Some state Medicaid programs pay for only the seven basic services; other states pay for thirty. Patients with less than full financial support are in some jeopardy, with dual-class care returning. Support for education and research is becoming even more difficult as the financial squeeze gets worse. Services which can be provided profitably outside the hospital are being developed by entrepreneurs, leaving large urban and teaching hospitals with only high-cost services. Corporate reorganization and multiinstitutional arrangements are being developed as strategies to cope with these pressures. In the midst of these shifts is the debate on competition versus regulation as the appropriate strategy to contain costs.



The immediate future of financing health services is filled with uncertainty regarding new arrangements but certainty regarding the result: less or no growth will be financed. All payers are seeking ways to slow the escalation in their purchases of health services. Government-sponsored entitlement programs have generated expectations that care will be available when needed. Recipients of such entitlements have benefited from access to services which either were not previously available or were available in less than satisfactory circumstances. In some areas decisions have already been made, and in others consideration is being given to reducing services for which government-sponsored recipients are entitled.

An alternative to reducing eligibility or paring benefits is simply to pay less for services. Given the general consensus that health services costs are already too high, and that the health sector already has more than its share of resources, it is not a large step to put a ceiling on what a payer is willing to pay for a given service. No longer can programs or expenses be implemented because they are an appropriate response to an identified need and are eligible for reimbursement. Willingness to pay is a new criterion.

A March 1982 paper from the Prospective Payment Task Force to Carolyn Davis, the administrator of the Health Care Finance Administration (HCFA), described our current environment in this way:

The present system of cost reimbursement of hospitals for services provided to Medicare beneficiaries stifles competition, carries with it the need for extensive federal regulation and is a major factor in the rapid growth in hospital costs. In large part, the system of retrospective cost reimbursement has been one of the major contributors to high rates of inflation. By reimbursing essentially any cost incurred, this system does not provide incentives to hospitals to manage their operations in the most cost-effective manner. On the contrary, well-intentioned hospital managers face pressure to spend more. The system does not serve the purpose intended in that it contributes to the instability of the Hospital Insurance Trust Fund, a situation which threatens the security of present and future beneficiaries. The system defies control and makes predictability of payments even at the highest level of aggregation an uncertain art, at best. Providers are not served by a system which exudes pressure to spend more, yet carries with it the extensive costs associated with a regulatory model and which, in their eyes, pays less than its fair share. Other third-party payers are not served because the ever growing pressure to decrease federal outlays, in the face of systemic pressure for hospitals to spend more, will continue to create

intense pressure on their payment systems.

It seems to me that the HCFA understands the problem.

Reports from Washington abound with proposals to reduce federal outlays for health services. Although the president's budget has been rejected, some elements of it may survive as Congress wrestles with massive budget problems. In order to save more than \$5 billion in Medicare and Medicaid costs, Reagan proposed shifting costs to beneficiaries, hospitals, physicians, private and federal employees, and states. There were thirteen expenditure cuts proposed in Medicare and nine in Medicaid, all aimed at the short-term solution of reducing expenses. While our industry lobbies may successfully keep these particular proposals off the table, others will clearly surface. As Senator Dole told witnesses at a Senate Finance Committee hearing, the question is no longer whether to cut, but where. David Winston, former Senate staffer and administration aide, reported that it matters very little to the Reagan Administration or to Congress how money is cut from the health sector, only that sufficient cuts are made. He indicated that an amount will be determined which must be cut, and then decisions will be made about where to secure it, using every method of regulation possible. It will not necessarily be rational, but it appears necessary.

Beyond this short-term goal, the long-term strategy of the administration seems to be to reform the method of financing health services. Prospective payment seems to be a logical first step, and the American Hospital Association (AHA) has served a useful role in putting forth a plan for debate. While some have already proclaimed the AHA proposal inappropriate and/or harmful to this or that element of the health system, it has at least pushed all segments to serious discussion of an alternative to the status quo other than more nibbling away at current arrangements.

The long-term Administration goal is to implement its competition strategy. Although still not released, reports of its demise are evidently premature. Schweiker, secretary of Health and Human Services, has reiterated his procompetition legislation which, reportedly, is to be sent to Congress this month with three key features: a Medicare voucher system, a cap on employees tax-free health benefits, and a tax-free rebate for employees who opt for inexpensive plans.

Another quotation from HCFA's Prospective Payment Task Force adequately describes Administration goals:

Any replacement system must meet certain objectives. It must be compatible with the Administration's efforts to forge a competitive industry-wide system and it must be a system that will serve for a reasonable period of time. The new system must provide restraint on the

growth of federal outlays and the growing instability of the Hospital Insurance Trust Fund. Ideally the replacement should not add to total system costs. In addition to control, the system must allow reliable predictability of expenditures so that federal and hospital, as well as third-party payer, planning can be effective. It must stimulate certain behavior in all parties to the system. Beneficiaries should be cost conscious, providers efficient and competitive, and payers able to get the best package for those they represent. Finally, the system should be easily understood by all involved and administered with a minimum complexity.

The task force outlined several options to change the financing system, which presumably would assist them in achieving that set of goals:

Option I: Prospective payment by grouping. This option would establish a prospective rate per admission. Its variations are: (A) adjust admissions for case mix, and (B) adjust admission payment rate for hospital type.

Option II: Indemnity fixed fee payment with beneficiary responsible for excess overcharges. Its variations are: (A) per diem indemnity, (B) per admission indemnity with case mix adjustment, (C) per unit of service indemnity, and (D) beneficiary co-pay beyond prospectively approved rates (a la Section 233 limits).

Option III: Competitive bidding. This option has five components: (1) off-line diagnoses, that is, the so-called national markets for those very esoteric kinds of diagnoses which can be done in only a few centers across the country; (2) tertiary care; (3) standard diagnoses (most); (4) only hospitals in large SMSAs; and (5) winning bid is the lowest rate per Medicare day, with penalties and incentives for length-of-stay (LOS) performance.

There would be incentive for beneficiaries to go to low-bid hospitals, that is, their deductibles would be paid. If the beneficiary chose to go to a higher-cost hospital, which he would be free to do, he would pay the excess costs beyond the area low bid per Medicare day in that hospital's charges.

A variation on this same theme would be to allow large organizations, that is, intermediaries, insurance companies, or multihospital systems, to bid for services for an area at several hospitals, even mixing Medicare with private business to increase their leverage.

Option IV: Payment of individual case rates. This is similar to the first option in which there would be a fee schedule for standard types of admission, adjusted for area and

type of institution.

Option V: Control over the rate of increase of the hospital's cost per admission to that of prices in general with no intensity allowance.

Option VI: Individual hospital budget review by HCFA or designated agents based on national or regional norms.

Option VII: Individual hospital negotiated rates.

Option VIII: Capitation. A regional allotment of funds to be spent on hospital services for beneficiaries would be established and a contract struck with a government agency, an intermediary, or a nonprofit commission to arrange for hospital services. The contracting organization would be at risk to deliver the services for the fixed contract price.

I think that the importance of these options lies not in the details but in the fact that they represent a line of thought by HCFA and Administration officials. Regardless of previous inadequacy of payment, we are now past (or almost past) the time when we got paid for what we did. That was called retrospective cost-based reimbursement. Now we must learn to do that for which we get paid. This conclusion is harsh when stated this way, because the distinction between getting paid for what we do and doing what we get paid for is substantial. No longer will we be able to devise, develop, implement, and be reimbursed, even though what we do may be in the best interest of our patients. With limited resources, we will have to devise cost-effective ways to deliver the services, subsidize the service with revenues from other areas, or curtail programs which are not deemed cost effective. It is inevitable that such changes will be painful to providers as we learn how to respond effectively to different incentives. Of greater concern is the likely ethical dilemmas which financial limits will create when available skills will not match available dollars. Our industry coped with this issue before 1965, but not without considerable difficulty. That stress seems likely to return. Obviously, our field is not oblivious to these pressures. Hospitals are taking a variety of steps to position themselves for coping effectively in a difficult environment. The development of multiinstitutional arrangements, corporate reorganizations, preferred provider arrangements, marketing staffs, for-profit subsidiaries, and new associations for cost saving and capital formation is aimed at assuring institutional survival. These are understandable, probably necessary, and we hope effective strategies for individual institutions.

On a national basis, there are considerable efforts by each of the national organizations which represent different segments of the industry (both institutional and professional) to devise and offer solutions to these public policy issues. The diversity and ingenuity of our colleagues will no doubt bring

forward a variety of solutions which are not simply self-serving but serve the public. To do so, we will have to be careful to prevent the self-interest which each organization feels in representing the needs of its particular membership from obscuring our broader public purposes. It is tempting for each organization to look out for its own, forgetting the fundamental reason for its constituency's existence.

We must not allow professional or institutional differences to divide providers, whether by arrogant attitudes about the superiority of our particular role, status, program, or manner of operation; or by disinterest in what we may view as someone else's problem (with a sigh of relief that it doesn't concern us), or by envy of others who operate in a more favorable climate. Having such feelings may be natural, but, as professionals committed to a public service enterprise, we must not succumb to them.

As we articulate these circumstances in public forums, not only must we describe them in terms which emphasize their human (as opposed to their organizational) dimension, but we must also speak with a common voice. It will be tempting for one segment of the industry to speak to its own peculiar needs. Such self-serving approaches will miss the mark and allow us to be set against each other in a competitive manner rather than work together to serve a mutual purpose. History suggests that society will continue to make resources available to the extent that we convey to the public our commitment to be of service and demonstrate our skill in delivering services efficiently and effectively.

Our view of our responsibility cannot be limited to the patients whom we serve or wish to serve. We must embrace a broader commitment to the public at large, regardless of where they live or their circumstances, or whether our particular program or institutions will ever serve them. Our focus must be on assuring that anyone who needs services has access to them, even though we may not be the direct deliverer of those services. When any provider is diminished in its ability to serve, an additional burden is placed on the rest of us to assure that the community's health care needs are addressed.

The nub of our public presentations must be to advocate the needs for support of essential patient services in the context of the public's responsibility. There has never been a more important time for providers to articulate the public's responsibility to provide adequately for its health care needs by establishing an effective partnership with providers. Failure in this task will create unnecessary and painful burdens, not only for providers but for patients as well.

We have so embraced our commitment that we tend to assume that we alone are responsible for the availability of services. Our professional and institutional responsibility includes

advising the public of available expertise and arranging for its effective and efficient delivery to patients. However, it is still the choice of our patients and the public to allocate sufficient resources to make this possible.

Thus we have a shared responsibility and, therefore, an additional duty to develop understanding and support from our public partner in what must be viewed as a common endeavor, not our private enterprise. The adequacy of services for our patients depends on achieving this understanding.

CHAIRMAN ANDERSEN: Tom, you talked about the individual hospital's role in working with other providers and organizations in the community and representing the public interest, but it seems that competitive strategies are emerging which some think will bring us the fruits of the market approach, and in that competitive strategy, some of the players get hurt. Some suggest that this is to be expected, and ultimately the system and the public will be better for it. How does that fit in with the general theme of your presentation?

MR. SMITH: It seems to me that the question we have always faced as administrators of hospitals is, Whom do we serve? Some, perhaps most, of us got into this business because we thought that we were entering an industry which was committed to a public service and that our role was to insure that the public got what the public needed. However, we learned very quickly, very early, who signed our paycheck, and how we were rewarded and promoted: we were promoted because we advocated the interests of our institutions.

We have always convinced ourselves, and I think generally accurately, that what is good for the institution is good for the community. Clearly many sins have been committed under that guise, just as a great deal of money has been spent wastefully under the rubric "It's good for the patient."

As we change the incentives in the system, some institutions will get hurt. Perhaps some should not survive. This conclusion is easy if one considers only the macro level. However, at the level of our own institutions, this conclusion is very, very difficult. Clearly the institution that ought to go out of business is never ours but somebody else's: the one down the street or in the next town. Perhaps there ought to be some closings, and I think there will be. In fact, they have already been occurring, particularly in my part of the country.

It is important to emphasize that if we lose sight of our fundamental reason for being in business--that is, to serve the public--our institutions will be in trouble. Those who are making public policy at the moment are tired of all our arguments. They do not care about all the constraints which we allege exist for us. They want to hear something from us that will serve what they view as the public interest, and currently

they are defining the public interest as a reduction in expenditures. It does not matter how we achieve reductions, whether by removing the nursing differential, a 2 percent cut, 223 limits, or anything else you can name. The bottom line is, we must spend less money, and if spending less money means we close institutions, institutions will be closed.

I talked yesterday to Speed Gebuldig in the AHA Washington office. According to him, nobody in Washington these days really cares anything about health services; it is difficult to get people in Congress to sit on committees involved with health services.

I think that says some good things about us. It says that people are no longer worried about the kind of access problems which we spent the last twenty years worrying about. It says that we have done a good job of responding to the incentives given us and have established systems which seem to be serving their constituents so well that people in Congress no longer get complaints from their constituents about lack of access.

Gebuldig reminded me that, during the last presidential campaign, Senator Kennedy made one speech on health services, his national health insurance pitch. It bombed. Kennedy never mentioned it again. None of the other candidates mentioned health services. There was nothing in the Republican Platform on health services. It is not a big issue. It is an issue only because it is interfering with other things that are important issues, and its interference is only a budgetary interference. Clearly, they are going to figure out ways to solve that problem, whether it means cutting \$2, \$3, \$4 billion or more.

In the process I think we as providers have to be very careful that we do not appear to be merely self-serving, protecting our hospital, our institution, or our program; instead, we must make whatever advocacy arguments we can in the context of describing how the public will be affected by those decisions. However, having lived in a regulated state for five years, I must say that it is very, very difficult to demonstrate the precise patient impact of a 1 percent cut in your budget: Who will not be served? What services will be missing? What difference will their absence make? These are tough questions.

MEMBER: Tom, can you say a bit about the posturing of the insurance industry, the commercial industry in particular? Are they doing anything besides taking out ads and talking rhetoric? Are they closing ranks on the composition of the competition bills?

MR. SMITH: Connecticut is obviously not known as the auto state but as the insurance state, and insurance agencies are the biggest proponents of the regulatory model. They would much prefer that we continue along the lines of a regulatory approach, a budget review approach, however structured, rather

than move to a competitive approach. They evidently think that they will benefit much more if the regulatory model is accepted.

RICHARD W. FOSTER: Insurers are exhorting the institutions not to pursue this issue from their own self-interest but to take a much broader perspective. What do you think are the prospects that institutions will take your exhortations to heart?

MR. SMITH: While institutions may not do so, I hope that our collective behavior will reflect this understanding. We have to learn that our individual organizations have no purpose other than to serve the public interest. If we fail to acknowledge that, we have no right to be in business.

Our trustees are responsible people, and trustees generally want the best for their own institutions. However, they are finding themselves in a dilemma as they consider that last year, costs in the hospital field went up at 18 percent while the CPI went at 9, and many are beginning to ask tough questions.

Unfortunately, the incentives in the current system are such that I do not think things are going to change unless we somehow change the incentives. Thus I advocate that we collectively as an industry change the structure in some way, whether by prospective payment, competition, or something entirely different. Clearly, in my view, we must get away from a cost-reimbursement model or our problems will get worse.

No, I do not expect individual institutions to decide to do without the latest technology and new equipment, to opt for 1960s medicine, to pay half the wages everyone else pays. That will not happen.

MEMBER: In line with that, would you think it is more plausible, for example, that teaching hospitals will support competition or something of that sort?

MR. SMITH: Not unless there are some provisions built into it to give recognition to those things we do which are in addition to patient care services. Teaching hospitals are in the same business as other hospitals, but they are also in some other "businesses," and we have traditionally played Robin Hood by attaching to all of our patient services a tax to support those other businesses. That would not be acceptable under a competitive model, and thus we would drive our teaching hospitals out of business--which I think is not in society's best interest. However, it is up to us to advocate for teaching hospitals and to persuade society that if it expects to have replacement manpower and to develop new knowledge and technology, it has to pay for that. As I tried to indicate earlier, the amount society is willing to pay is a matter for society to determine, as it has done in financing biomedical research. We have never sufficiently fostered that desire to



finance professional health education, and perhaps that is the next logical step--to set up a federal funding source for professional health education; decide as a country how many doctors, nurses, and other health providers we will finance; and let those who want to be in that business competitively bid to be in that business, while they are also competitively bidding to be in the patient care business.

JOHN A. WITT: Tom, you indicated that history says the public will back us if we tell our story, but when are institutions going to tell their story? If we talked to the public, I have a hunch that there would be some people who would listen. Why are we so reluctant to put the issues before the very people whom we are trying to serve and for whose sakes we want to remain in business? Instead, we seem to be alone at the mercy of the regulators.

MR. SMITH: John, I know there has been such reluctance, but I am seeing increasingly less reluctance and more aggressive efforts by hospitals and multihospital groups to tell that story in a variety of different ways. In my own state an increasing number of institutions are taking out newspaper ads to do just what you said. For instance, a number have begun publishing their annual reports in newspapers, using ads like Mobil Oil's "editorials." Our state hospital association has begun to do the same thing on behalf of all the institutions in the state.

So I think you are right; we have perhaps been too reticent about that, but I see more and more of it. However, I worry that if it is done in a crass, overcompetitive manner, with each institution touting itself and putting down the others in town, then I do not think the public's best interest is being served. If we articulate why the services we provide are necessary, essential, and in the public's best interest, I think we will have helped ourselves in those regulatory arenas.

I give you a specific example from my town. About a year ago the state regulatory body denied a CAT scanner to a hospital in our city. That hospital mounted a very effective public effort to tell why it was in the community's best interest that the hospital get a scanner despite the regulators' objections. The hospital talked to the local legislators, elected officials, area businessmen, unions, and so forth, who all agreed to include their names on a variety of the hospital's newspaper advertisements that basically said, "We got a raw deal, and we need to have it changed, and all of these members of the public we serve support us. The decision was reversed very soon. So I think such an approach can work and is being used, at least selectively.

GEORGE BUGBEE: What has been your increase compared with the 19 percent for hospitals overall?

MR. SMITH: Last year in Connecticut I believe it was 12 percent.

CHAIRMAN ANDERSEN: It seems that your essential message, Tom, has been that, given that there must be cuts in health services costs, it is difficult to determine which cuts would be most effective. But don't we have to be able to specify where and how cuts should be made, to protect the public's interest?

MR. SMITH: As David Winston said, it really does not matter where they make the cuts. They are creating a budget goal by categories. Yesterday they said they would cut \$3 billion in Medicare, last week it was \$5 billion, and the week before it was \$2.5 billion. As long as one is dealing in those aggregate terms, you cannot focus very specifically on where cuts will occur. There will be cuts, and they will be large, multibillion-dollar cuts. Obviously, our lobbyists from the AHA and the Federation and the AAMC will try to insure that the cuts occur in the least painful areas, but it will be hard to take several billion dollars out of the system without its being painful to somebody somewhere.

The more fundamental reform is that which is being advocated by the AHA in creating a prospective payment proposal. The first problem with that proposal is that its budget target is far from what the current budget goals seem to be: it proposes saving \$1 billion, and they are talking about \$3 to \$5 billion.

Second, this proposal seems to suffer because it is being advocated by the industry, which is somewhat ironic. It says something, I guess, about our standing there, but because it is advocated by the industry, it is being viewed, I am told by the AHA staff, as perhaps being too self-serving.

I think the burden is on us to advocate something different. I don't think that nibbling away at the edges of the system will change any fundamental behavior in my institution. If Medicare changes a few rules here and there, my chiefs of services and the department heads are not going to change their basic behavior. What may alter it is a change in the whole financing system and the incentives by which they get rewarded. Whether prospective payment is the right approach, I don't know, but I am delighted that at least something other than thirteen more adjustments to the current cost-less formula is on the table.

MEMBER: What health care costs can be contained, and what would be the political strategy? In a recent New York Times series on the health care crisis, Americans were asked, "What would you give up to help make health care costs more affordable?" People said that they would give up practically everything: personal relationships with physicians, going to clinics, pay deductible. However, they would not give up high technology. Since health care costs are driven up by high technology, and I would be somewhat pessimistic about anything

short of socialized medicine controlling technology, perhaps the hospital industry is in a political no-win situation.

MR. SMITH: I think you are right, and we are in that situation because so far we do not have a good option to put forward which will make everybody happy.

Somebody is going to lose, and I think providers are going to be the whipping boy at the outset because the general view is that we already have more of the resources than we need.

MEMBER: Would responsible leadership in the hospital industry begin to rethink the role of high technology, since that is the basic issue?

MR. SMITH: I am not sure that the industry would agree that that is the basic issue. If what you are advocating is that we slow down technological development, you will not get much support for that. However, if what you are advocating is effective use of technological development, everybody would agree to that, but we will disagree about what is effective and when it is efficacious to put it into use.

MEMBER: Isn't the real issue, though, effective utilization of doctors and hospitals, how often people seek care, for how long, and how much care?

MR. SMITH: That is the issue, and so far none of the proposals deals with that, because that would mean controlling physician behavior and how physicians make judgments about what services are required.

I have just joined another committee that will try to wrestle with that. How does one create incentives for physicians to utilize the system more efficiently? Constraining institutions will not necessarily change physician behavior unless we so constrict the system that it ceases to provide options for physicians. For instance, if we reduce beds in an area, there will be fewer beds available. Presumably you will change physician behavior indirectly by affecting length of stay and increasing through-put, but I do not think anyone has a good handle on how to affect physicians directly, other than to force the HMO model.

MEMBER: People on Medicaid maintain they have restricted access to medical care, but I maintain they have the greatest access to medical hospital care of any segment of our society. This must change. Patients go from one hospital to another hospital and from one doctor to another doctor, and this is costly. That is the system that must change, and it can be changed. It has changed in Detroit where they have gone to the HMO. Out in Colorado they are mandating the HMO-type care. I think it has to be considered from the socioeconomic standpoint.

JOHN IMHOFF: I recently heard a talk by the director of the PSRO for the state of Delaware, and it seemed that their program was having quite a profound effect on the physician and the methods that had been used and are now being used to practice.

CHAIRMAN ANDERSEN: What seemed to be the key to their approach, John?

MR. IMHOFF: Much more scrutiny, peer review, profile studies, data banks on the activities and characteristics of doctors, investigation of admissions of patients to the emergency room, increasing justification, studying numbers of surgeries without consultation. The director claimed that their program was not only having a dramatic impact on length of stay and cost, but it was also bringing about tighter professional ships in the state and, interestingly enough, according to her, was gaining the support of organized medicine in the state.

MEMBER: John, if that record were typical of the United States, there would not be such an effort in Washington to decrease the financial support for the PSRO program, would there?

MR. IMHOFF: Based on my own observation, that is one system that seems to be working pretty well, at least working well compared with others.

MEMBER: I think I can testify that in our state at least four of the major industries have picked up a major part of the support for the cost of operating the PSRO because they believe that it is affecting the cost of their employees' care. However, my hunch is that when that starts to hurt, the pressure will be on the people who are doing the hurting, which means that the doctors will put pressure on the doctors that make up the PSRO. So I think it takes a heap of faith to think that that will continue to work.

## THE STATUS OF MULTIHOSPITAL SYSTEMS

Howard Zuckerman

CHAIRMAN RONALD M. ANDERSEN: Our first speaker for this session is Howard Zuckerman. Howard is about to be appointed director of the Program and Bureau of Hospital Administration at the University of Michigan. He received his M.B.A. from Xavier University and his Ph.D. in Medical Care Organization at the University of Michigan. He also has managerial experience, having served as vice-president and manager of Bethesda Hospital in Cincinnati.

We are fortunate to have Howard on our program to set the stage and give us a systematic picture of multihospital systems and the trends in their development. He has recently published a book on the subject and will bring us up to date on what has happened since his book came out.

HOWARD ZUCKERMAN: Thank you for inviting me. It is a particular privilege to be at a symposium bearing the name of George Bugbee. As I suspect many of you know, Lou Weeks from Michigan has been conducting a series of oral histories with a number of noteworthy people in the field, one of whom, of course, is George. In the fall and winter issues of Health Services Research, a two-part series is being run, featuring that first round of interviews with George. I was struck by at least one part of the interview, that which had to do with the negotiations some years back when George was looking for a new home for the Health Information Foundation and had whittled his options down to Chicago and the University of Michigan. Although there was apparently a great deal of interest on George's and Odin's part in going to Michigan, for a variety of primarily managerial reasons, George made the decision to start what is now the Center for Health Administration Studies here at Chicago. Clearly your gain, our loss.

First, and very briefly, I want to give a status report on the magnitude of the growth and development of multi-unit systems. Then I will attempt to provide some context for the presentations scheduled for the next day and a half. I would like to look at a set of what may be opportunities--strengths, if you will, of multi-unit systems, the kinds of contributions one could argue that they would make, and I will attempt to back that up with some of our limited research findings to this point. I will also talk about some issues these systems face, some of which may be viewed as threats rather than opportunities.

Looking at current status, I would remind you of the AHA's definition of a multi-unit system: some form of corporate organization which is responsible for the executive management and/or policy for two or more owned, leased, or managed hospitals. You are all familiar with the broad array of

multiinstitutional arrangements which exist. The caution at this point is simply that, when we talk about some of the numbers, keep in mind that things like shared-services arrangements or consortia are not included in the AHA definition. So fundamentally we are looking at entities like results of mergers, management contracts, leases, holding companies, satellites, and so on.

According to the AHA, based on their 1981 data, currently some 32 percent of all nonfederal community hospitals and 36 percent of all nonfederal community hospital beds are counted as some kind of multi-unit system--roughly a third of the industry. Of that 32 percent, 19 percent are not-for-profit hospitals and 13 percent are for-profit hospitals. Of the beds, 26 percent are not for profit, 10 percent for profit. These numbers aside, there are two key factors: (1) there is significant market penetration on the part of the multi-unit arrangements of one type or another, and (2) market penetration is increasing.

Since 1945 there has been a fairly dramatic growth in the number of multihospital systems as a percentage of all nonfederal general and specialty hospitals. Where is that growth occurring? Consider these categories: (1) Hospitals in Catholic multihospital systems have had a steady but fairly slow rate of growth over time. (2) Hospitals in other not-for-profit systems have experienced a somewhat more rapid increase in recent years. (3) Other religiously oriented or owned systems, a fairly small percentage of the total, have also had some growth. (4) Investor-owned systems have had the most rapid growth. Thus multihospital systems in general are increasing at a fairly substantial rate, and among the major types of systems, it is the investor-owned sector which is growing most rapidly.

To give you more data: Of all the systems that exist--according to the AHA count, approximately 250--close to half are Catholic systems. Furthermore, 88 percent of all the multihospital units are not for profit, 12 percent for profit.

Another piece of data has to do with the kinds of arrangements that exhibit the most rapid growth, and of those, management contracts is the area in which we are witnessing the most substantial rate of increase. Management-contracts arrangements now account for some 460 hospitals around the country--that is, some 460 hospitals are managed under contract to somebody. In two-thirds of the cases, the "somebody" is an investor-owned organization. A couple years ago investor-owned organizations had about 80 percent of the management contracts; now it is 65 percent. Perhaps this suggests some change in posture on the part of the not-for-profit institutions.

Most systems tend to be fairly small. The conventional wisdom often appears to be that, when we talk about "systems," we are talking about large, monstrous organizations. But 70 percent of the multi-unit systems in this country consist of

five hospitals or less; most consist of three. So by and large we are not talking about enormous organizations.

Now to discuss some of the strengths and the opportunities that systems may offer us.

First, I think Tom Smith said it very well this morning in laying out a number of reasons systems have come about in the first place. By and large, I would agree with what I think was his conclusion--that multiinstitutional arrangements are fundamentally a response to environmental change, to environmental turbulence, to constraints, to contingencies in the environment in which we live. Thus, in that context, we can view multiinstitutional arrangements as an adaptive managerial response to environmental changes.

By forming these systems, organizations attempt to lay out a set of strategies and create structures to accomplish several things: first, to provide sufficient strength in order to cope with that turbulent, changing environment; second, to provide mechanisms by which to acquire the scarce and valued resources that they need: financial resources, human resources; third, to allow the organization to maintain some sense of stability; and fourth, to provide the opportunity to survive, to grow, and/or to carry out a mission of service. The last task is particularly the case in many of the religiously sponsored organizations.

We can view the strengths of the systems and the opportunities they offer along three dimensions: first, economic benefits; second, human resource or manpower benefits; and, finally, social and political impacts in terms of the hospitals, the system as a collectivity, and the communities being served.

Let us look first at the economic benefits of the multiinstitutional system. One of the presumed strengths of systems lies in their ability, largely through economies of scale, to have some impact on at least the rate of increase in cost, and we see a substantial amount of joint activities or ventures of one type or another, such as shared purchasing arrangements. The research literature and much popular literature reports achievement in this area of reducing the rates of cost increases, but I note that most of the achievements have been made in the administrative arena, that is, in such things as the purchasing of laundry. We have not yet seen very much by way of joint activities in the clinical area where, one could argue, the real dollars lie.

There is some evidence that the systems are making some strides in the areas related to productivity and staffing. We recently completed a study for the W. K. Kellogg Foundation which had to do with the impact of management contracts on the individual hospital's management of the contract. One of our major findings was that, while the number of staff members per

unit was not necessarily reduced, there was a substantial reduction in the variability around the mean, around the average staffing, suggesting that, in these contracts arrangements, there were conscious steps toward improving the predictability and the control of the use of personnel resources--a movement toward some stability, if you will, in staffing.

One of the things that we may want to watch carefully with regard to opportunities in multiinstitutional systems is the diffusion of management technology throughout the organization. In, for example, scheduling systems, control systems, staffing systems, budgeting, and so on, these multi-unit arrangements ought to have management technology which can be diffused much more quickly over a much broader base than if we were working in a single hospital, one after another after another. So the increase in the rate of adoption of such technology represents, I believe, a real potential contribution for systems in the context of their economic impact.

In terms of use of resource capacity, it is not yet clear that systems have had very much impact in this arena. This would probably be most likely in an area where systems are located with units geographically proximate to one another. However, my understanding at the moment is that we have not yet made substantial improvements in the use of resource capacity, although such improvement is on the agenda.

With regard to operating performance, the picture is mixed. That is, some studies suggest that we have increased productivity. We may have made some reductions in cost and so on. Other studies suggest just the reverse, that systems have in a number of instances increased costs. Why that has occurred is not entirely clear. One argument often offered, however, is that, particularly in the early stages of system development (and many systems are still in early stages of development), the agenda is concerned with increasing services, with recruiting and retaining clinical and administrative personnel, with providing previously unavailable services and technology. These kinds of service and resource improvements increase costs--at least in the short run. However, in the management contract study, we were somewhat impressed that, among the hospitals being managed under contract, we did see fairly rapid improvements in profitability, improvement in financial ratios, and, frankly, somewhat to our surprise, a reduction in the rate of increase in expenses.

Many people, particularly in the nonprofit sector, have contended that the access to capital may well be the strategic issue of the eighties. Will multiinstitutional systems have an advantage in that arena? Evidence thus far suggests that, indeed, systems have better access to capital than do free-standing organizations. If you look at the set of organizations with AA and A ratings, for example, you would find that multi-unit systems are disproportionately represented in the higher



credit ratings. So systems have advantages since they are perceived by lenders, by the investment community, as lower credit risks, as able to spread their risks over a larger base. And to the extent that there is capital available over the next several years, one might argue that systems will have a significant advantage acquiring it.

In short, in the economic arena, although we have a mixed picture to this point, there are substantial opportunities for systems in terms of economies of scale, diffusions of technology, and access to capital.

Multi-unit systems offer a number of opportunities in our second area, that of human resources. In terms of management, the evidence thus far suggests that the systems have a good record in the recruitment and retention of administrative personnel and that these kinds of organizations are very attractive to people coming out of administrative programs such as the one here at the University of Chicago and at the University of Michigan. Multi-unit systems are large, complex organizations, with substantial resources available on a system-wide basis--for example, backup from the corporate level for those who are working at a local or divisional level. These systems also have more opportunities for career mobility, that is, the opportunity to assume different kinds of roles in different kinds of settings in the context of the single organization is viewed as part of the attractiveness of systems to managers already in the field or to managers just entering the field, especially the people we might call "generalists."

Functional specialists also operate well in multi-unit systems. These people may come from a variety of places but have particular expertise in such areas as planning, finance, reimbursement, management, engineering, information systems, risk management, and research. A large organization can afford such talent, whereas single, free-standing hospitals might have difficulty doing so.

I would argue that one of the major strengths of the multi-unit systems lies in the area of management capability. Indeed that capability may well be the key determinant of which organizations successfully cope with an increasingly constrained environment.

In the governance area, I think so far it is fair to say that multi-unit systems have many opportunities which they are still in the process of developing into improved performance. We have a long way to go in that arena, and some have argued that the context of systems may well offer us a vehicle by which to tap and nurture this initial dimension of our organizations.

Let me add here that, in terms of management and governance issues, a number of religious organizations are witnessing a decline in the number of religious; thus they are faced with the

difficulty of how to maintain the central value-set of religious organizations when the religious are declining. Some of the organizations are using the governance-management structure as a vehicle by which to assure that the value-set, the mission, and the philosophy of the sponsoring organization continue over time even in the face of the declining numbers of members of the religious community. For many organizations, that is a very crucial element and a very important factor in the continuing growth and development of systems.

With regard to physicians, there is some evidence that systems are doing reasonably well in terms of their ability to recruit and retain them. A number of systems, in fact, have made this an identifiable activity at the corporate level. Physician recruitment, particularly in systems that have a large number of hospitals in rural areas, is looking rather promising. In the management contract study, we noted substantial increases in the numbers of physicians that were brought into the rural hospitals which were part of the larger system.

Many things in the context of the larger system may be attractive to physicians in terms of the organizational capabilities. So this is an area we need to watch carefully, since in the long term it could be of help to us, despite the fact that we read about a 50 percent increase in physicians over the next decade. I am personally not convinced that in some parts of the country the increase will resolve the distribution problem. Odin is always pointing out to me that we do not have any data on anything important, and, therefore, any of us who stand at a microphone can speculate on virtually anything we want. Nonetheless, I hypothesize that the areas of this country which traditionally have been unable to attract physicians--for example, rural areas and inner cities--will not necessarily be better off because we have increased the supply of physicians. The fact is, the things that have made those areas unattractive are not necessarily changing.

Whereas we may view the increase in the supply of physicians as an opportunity for us to improve recruiting, another hypothesis is that, as we get more and more physicians, they will compete more directly with us for services, particularly some of the lower-cost services, and then we may have more problems in the cost of hospital care.

At any rate, by and large, at this point it is fair to say that whether we are talking about managerial personnel or physician personnel, the performance of multi-unit systems thus far has been pretty good, and I would argue that it represents an area of major opportunities for such systems over time.

In terms of the third area, that of the social and political organizational opportunities, systems have accomplished at least this: They have allowed some organizations to survive. (The broader social question of whether all the organizations that

have survived should have survived is, like this morning's question of rationing, one that I will not get into here.)

On the other side of the survival question is the matter of growth. It is becoming increasingly clear that the formation of systems has as one of its major attributes a vehicle by which to enact organizational growth. This growth is taking place in a variety of forms and structures. We are seeing organizations' systems look at new service populations or new markets, the provision of new services or products, and opportunities for diversification--sometimes into health-related services, in some cases into services that are not health related. All of this is part of the growth strategy in order to maintain organizational stability, to develop new sources of revenue, and to protect current markets and referral patterns which will become increasingly important over time. Many of the strategies are designed explicitly to reduce our dependence on inpatient revenues, the area of most regulation and of most concern to many of us.

So by and large, the systems are showing themselves to be major vehicles through which to enact growth, the growth itself taking on a number of forms, for example, some organizations move, as is largely the case in the investor-owned sector, to multistate, multiregional kinds of settings.

We are starting to see some interest in regional and local integration, some vertical integration of services, particularly among the not-for-profit organizations. Vertical integration may have delivery and economic impacts. Vertical integration to this point has involved offering new and different kinds of services to either the same or new populations; it has not always been a substitution, for example, of outpatient for inpatient services or even ambulatory surgery for inpatient surgery. It has been an add-on, and so for the time being costs continue to rise. But if the move toward vertical integration is a strategy for making services more responsive to community need and at the same time having an impact on an economic issue, then it seems to me the question of substitution becomes pretty fundamental.

Another note with regard to some of the social and political benefits: One of the most significant findings in the research on systems thus far is that a major contribution has been in the increased availability of and access to care. Availability and access appear to be getting lost in our agenda these days, which is focusing primarily, if not exclusively, on cost issues.

I do not believe that the access-availability issues have been resolved, and many of the recent developments at both the federal and state level are tending to make the situation worse, not improve it. But systems have increased the availability of and access to services, primarily hospital services. Thus, if we have costs on one side and availability of and access to

services on the other, there is some explanation of why the economic benefits have not yet been achieved.

Another opportunity in this general arena has to do with the role of systems in a political sense. There is an argument to be made for their size and strength and all that means in the political arena in negotiating with third parties of one type or another, with planning agencies, the Blues, and so on. A fairly formidable negotiating stance can be offered by large, strong systems, and I think that their clout in the political arena will be felt increasingly over time.

Which leads me to the growing interest in systems of systems. Voluntary Hospitals of America, the Associated Hospital Systems, the Sun Alliance, and United Hospitals, among others, represent basically alliances of, in many cases, already large, strong systems. They represent a substantial set of hospitals, beds, managerial talent, and the like. While much of their activity to this point has been in the areas of joint purchasing, shared services and information, moving toward provision of management services through these alliances, some are talking about the possibilities of pooling their capital to get a still stronger position in capital markets. I think the area of politics is one where we may well expect to see some activity on the part of some of these alliances, so there is a substantial possibility here of a strong political role for systems and for what we might call the "supersystems."

However, there is another side of all this: some potential and some actual threats to the growth and development of systems. One is the whole arena of cost control, reimbursement, pressures to reduce utilization, tax laws, and so on. Many of the kinds of things Tom Smith discussed do indeed present threats to the economic viability of our organizations. Despite the fact that systems have been around for ten years, there certainly are not any financial incentives to form or maintain them. These systems have emerged largely in the absence of financial incentives. By and large, for example, hospitals continue to be reimbursed as free-standing entities.

Some of the major issues which many perceive to be threatening have to do with the continuing access to capital. Return on equity is a particularly large concern among the not-for-profit organizations. Potential for the loss or at least reduction of tax-exempt financing is a major concern.

Some of the stipulations in the Economic Recovery Act--which, some have argued, have tended to favor even further the investor-owned sector in contrast with the not-for-profit sector--all represent a set of concerns with regard to operating reimbursement, the ability to maintain operating margins on the one hand and the capital issues on the other, so these represent a whole series of potential threats to the growth of systems.

We discussed earlier and rather positively some of the governance and management opportunities that systems have. However, there is another side to that argument. On both the governance and management side, we are talking about the assumption of new roles, new responsibilities, perspectives quite different from those we have traditionally required of trustees and managers.

We must consider carefully the implications of moving toward large, corporate kinds of organizations and of thinking in terms of a view of the system and all of its parts, which is different from being concerned with only one hospital in one community. Those kinds of issues very quickly come to the fore, for example, in the discussion of moving resources from one part of the system to another. In large part because of our tradition of single, autonomous units, the notions of transferring resources from one community to another, using cross-subsidizations within the organizations, are relatively new. Likewise, questions of the levels in the system wherein resource allocations are made and the degree of delegation of authority among the various levels require careful attention and thought. Such issues must be faced and dealt with--but that does not make it easy. The situation is similar with respect to the role of managers. By and large, we have thought in terms of free-standing organizations. But the nature and structure of the industry is changing.

That means some differences in perspective. It is a question of inter- as well as intraorganizational concerns, of reporting to others beyond your local board, of limiting the traditional role of the hospital administrator in certain areas. Whether we achieve the opportunities available in this governance-management area will largely be a function of how well we handle this transition from what many have called a cottage industry to a more corporate-oriented environment.

For those of us in academic life, I might add that this raises some issues regarding the world which we are training our bright young graduates to enter. Is our curriculum consistent with the changing demands and needs of this field? The industry for which we are training people in 1980 is not the same as the one for which we trained them in 1970 or 1960. Therefore, I think it is appropriate for us to look at the changes, anticipate what the changes are likely to be, and make sure that our curriculum design is in line with that.

The growth experienced and fostered by multi-unit systems is not likely to be unbridled, and growth is not going to be determined solely by the organization which decides it wishes to grow. At the same time that the environment is becoming increasingly regulatory, it is also becoming increasingly competitive. We mentioned earlier that in a number of arenas it is entirely possible that we will be in competition with our own physicians for some areas of service, areas which for hospital

organizations may be highly desirable opportunities for growth and expansion.

We are certainly seeing competition, for example, for management contracts between not-for-profit organizations and for-profit organizations and among for-profit organizations. Even though we are seeing increasing collaboration among systems, it is also predictable that, as those systems grow, their service areas will overlap, and they will be increasingly competitive with one another for patients, referrals, physicians, and a variety of resources. So we find ourselves in an interesting situation characterized by increasing regulation and competition at the same time. And, although it has not been a major issue thus far, the question of antitrust is one that I believe is becoming increasingly prominent. If multi-unit systems represent a growing concentration of economic and political power, are there not some limits to the degree of concentration which is appropriate to the public interest? Over time we may well see more and more attention being focused on the growth and development of systems, particularly those which are becoming dominant in given markets.

In order to take advantage of the strengths and opportunities we have discussed and to offset some of the threats and risks just mentioned, one of the developments taking place is "corporate reorganization" or corporate restructuring, which is basically an adjustment of the legal structure away from the single corporate structure toward multicorporate structures, most typically, a parent holding company or several holding companies with a variety of subsidiary corporations, some for profit, some not for profit, some strictly health related, some diversifying into areas not related to health. Again, the presumed advantage of all this is as a response to a turbulent environment--the chance, it is argued, to protect assets and revenues, to avoid regulation, to enable capital formation (which is otherwise precluded through Medicare and other constraints), to maximize the reimbursement available to an organization, and to provide flexibility for growth. I would argue that the real, long-term benefits of corporate restructuring--as well as of multi-unit systems--lie in the governance and management arrangements.

However, there are some questions about this strategy. We still do not know very much about the extent to which all the benefits that have been claimed for corporate restructuring have been achieved, and, in fairness, it may be too early to tell. But we also do not know very much about the costs of restructuring. As I understand it, it is a fairly expensive proposition in terms of legal and financial fees, to say nothing of organizational costs. In addition, the risk of failure in new ventures must be considered. Especially when an organization moves into unrelated areas, failures may be perceived as signaling other problems. This is a particular concern vis-a-vis the investment banking community.

It is not yet clear whether the corporate restructuring we are witnessing is necessarily a long-run strategy; perhaps it is not intended to be so. Maybe it is intended to be a short-run strategy to stay a few years ahead of the regulators, in which case it may or may not be worth its cost. And, if restructuring is in many cases designed to take advantage of certain loopholes in regulations, what happens if the regulators begin to close the loopholes?

Based on the premise that the structure we adopt should flow from our strategies and should be built on our strengths, it seems to me reasonably important that we take a careful look at restructuring's implications in the long and short run, consider it in the context of what we are trying to accomplish, and then make decisions. Having said that, I must add that there is no question in my mind that corporate restructuring will continue at the rapid rate we have witnessed over the last couple of years. One way of testing its worth might be to examine some of the earliest organizations to restructure in order to determine if they have been satisfied with the restructuring arrangements.

At any rate, let me suggest to you that, by and large, the growth and development of systems represent more opportunities than threats for us. Such systems may be the vehicles through which we can make fundamental changes in the delivery of services and other necessary changes. However, in terms of information for operating and for policy purposes, there is still very much we need to know, such as the relative benefits of different kinds of organizational arrangements. In fact, we are trying to assess these systems' performances, but we need more information about structure and process. Furthermore, we still know very little about the impact of systems on the use, quality, and cost of services. At some point one might wonder whether systems have any effect on the health status of the people whom they serve.

We have made a beginning in understanding the dynamics and the impact of these organizations, their relative strengths, relative weaknesses, relative opportunities and threats, but clearly more work must be done. I realize that evaluation or assessment of a moving target is extremely difficult. There are problems of determining the criteria used to assess these or any kinds of organization. Whose criteria does one use? Do you focus on efficiency? On effectiveness? Some work is being conducted in this area: for example, the Associated Hospital System group, a joint venture among ten large multi-unit systems, is financing its own attempt to develop a set of system performance indicators. But needless to say, more research is required.

CHAIRMAN ANDERSEN: That was a very enlightening and stimulating talk. Any questions or comments?

DONALD CORDES: I want to mention the vertical integration that these systems are anticipating. They are attempting to acquire the major suppliers for which the big hospitals are the major customers, on the theory that it would be better not to pour money into another commercial enterprise but into companies that they themselves own. I think that is one of the driving forces of the individual regional systems, as I call them, and the supersystems.

DR. ZUCKERMAN: Some organizations are indeed moving in that direction. The only hesitation in my mind is the caution about extending managerial and governance resources beyond their capability.

MEMBER: I think your cautions about diversification are extremely important, especially when an organization gets itself involved in something it knows little about.

You said that managers as well as trustees will find it hard to take the perspective of the multi-unit system as opposed to just their own free-standing organization, and I liken it somewhat to the Frieson concept of designing a hospital in the 1950s and 1960s. Theoretically it might have been fine to do without nursing stations and to move patients and material throughout a hospital by means of conveyor belts, but practically, nurses were not trained in the Frieson school of nursing, so they wanted nursing stations. We must ask as we see all the people who were trained in a kind of cottage industry, How will they acquire the ability to become wild-eyed and risk-taking entrepreneurs?

DR. ZUCKERMAN: I am not sure that we want wild-eyed entrepreneurs. What we do want to assure in our graduate education is that our curriculum reflects the world as it is and as it might be. Further, it is essential that our students understand the balance between social mission and economic responsibility.

It is interesting to note that the managerial ranks of not-for-profit systems come from different places than do the managerial ranks of the for-profit, investor-owned systems. The not-for-profit systems are characterized by people trained in programs such as those at Chicago and Michigan. The for-profit systems, in contrast, tend to have managers with accounting backgrounds, legal backgrounds, non-HA types, if you will.

MICHAEL KLUGER: Have you noticed a skewing of multihospital setups toward any specific geographical region in the United States?

DR. ZUCKERMAN: Some areas have more systems than others. The New England area has a market penetration of systems of only 2 percent, that is, 2 percent of the hospitals and 2 percent of the beds are in systems. In the Midwest the number is



substantially higher than that. In the Southwest and far West, there is also a high degree of penetration. If you want to see some recent data on that, the AHA has information by region.

MEMBER: In part, can that distribution be explained by the fact that the Northeast and the East are the regions most heavily regulated, and so institutions there have not reorganized into multiinstitutional corporations?

DR. ZUCKERMAN: First, my understanding is that we are starting to see some growing interest in that arena. Second, I would note that, about a year ago, Hospital Corporation of America (HCA) opened an office just outside of Boston. HCA does not move into an area unless it thinks there is a pretty good chance of something happening. It does a very good job in planning and marketing, which suggests that there may be some things under way. In fact, it now manages several hospitals in that area.

There may be some things about the demographics and the economy of the Northeast that make it different from other parts of the country. The population tends to be older. Also, there are some very strong Yankee traditions in New England, traditions of fierce independence, and the notion of systems is contrary to that and, therefore, has not moved quite as fast as in some other parts of the country.

C. THOMAS SMITH: I agree very much with what Howard said. The only thing I would add is that that part of the country characteristically has a large number of teaching institutions, and in the whole multihospital environment, teaching institutions do not play a significant role. I am not sure if that is just reluctance on their part or a difference in mission. From our own institution's point of view, we have been involved with one contractual management relationship which I think was tolerated because it was something that I wanted to do, but the institution in terms of the leadership and trustees do not find that terribly germane to our mission.



## REACTOR AND AUDIENCE RESPONSE

Jeff C. Goldsmith

CHAIRMAN RONALD M. ANDERSEN: Jeff Goldsmith, a Ph.D. in sociology, is director of Health Planning and Regulatory Affairs at the University of Chicago Hospitals and Clinics. He was special assistant to the director of the Illinois Bureau of the Budget. Jeff is also the author of Can Hospitals Survive? The New Competitive Market for Health Care.

JEFF C. GOLDSMITH: Howard's remarks about diversification and corporate restructuring interest me because I share much of his skepticism. A couple examples will indicate why.

About a month ago, I was out at Health West, one of the most aggressive organizations in the not-for-profit field. Health West made headlines in the industry a year or two ago by acquiring a shopping center immediately adjacent to the North Ridge Hospital. There was an enormous amount of publicity about this, and hospital boards and administrations began to think that restaurants and bowling alleys were interesting businesses to get into, so a lot of them began acquiring restaurants and bowling alleys.

When I went out to talk to the people at Health West, I told them that their "diversification" had created quite a stir. This was greeted with tremendous laughter and uproar because they bought the shopping center for the land beneath it: acquiring the shopping center was the cheapest way to get twenty acres or so of extraordinarily expensive San Fernando Valley real estate. It turned out, however, that they lost their shirts in the bowling alley and restaurant businesses and were delighted to get out of it.

The other example of diversification is Sears's acquisition of Coldwell Banker, which is the nation's largest real estate firm, and of Dean Witter, a medium stock brokerage firm. Some of the wags in the brokerage industry are saying that Sears is going to begin marketing services through Dean Witter under the slogan, Buy Your Stocks Where You Buy Your Socks.

So I think there really is a core of wisdom in what Howard is saying about diversification. Managing health services, coping with the kinds of changes that Tom was talking about, trying to rationalize and get control over the health systems that are being developed around the country are extremely complex undertakings which will keep the existing managers and trustees of our institutions busy for many years. Thus it seems unwise to branch out into areas where we really know nothing.

I have some comments to make about Tom Smith's and Howard Zuckerman's presentations, and I will begin with Tom's.

He and I both attended a meeting in Washington last week of the Council of Teaching Hospitals. The keynote address at that conference was given by John Igelhart, one of the most thoughtful, moderate, reasonable observers of health policy in the country today. His view of the current state of evolution of health policy in the country was one of the bleakest and most depressing I have ever encountered. Essentially, he said that the consideration of how to arrange a system of health care financing had been reduced almost completely to the fiscal level, and there was no significant interest in or policymaking apparatus for seeing how those changes in health financing would affect the organization and delivery of care--not in HCFA, the secretary's office, OMB, or, significantly enough, in most of the congressional committees in which health care financing issues are thrashed out. The whole area has become enough of a morass that people of intelligence and talent, the Dan Rostenkowskis and Rangels of the world, have fled the health care area after a year or two of wading into it: the ratio of complexity and hassle to possible outcome was so high that they moved on very quickly to other areas.

The real concern that I have about the process that Tom has addressed is that the Administration came into office wanting to rearrange completely the ground rules under which health care is financed and to create a new dynamic within the industry, but this seems to have become a very low priority, to the point where the Administration has essentially divested itself of policy responsibility for Medicaid and has let individual governors begin to cut their own deals (and, in many cases, providers' throats) in local markets. For example, Illinois governor Thompson said, in implementing his new powers in the Medicaid program, Why provide Cadillac care for the poor when Chevrolet care will do? A Chevrolet cannot be run on a fuel mixture of half water and half gasoline, which is how I would describe the proposals that are being put forward now, and the Administration in Washington seems to be dealing in a completely ad hoc way with the problem of reducing Medicare spending.

In this process the view of the whole--the impact of health financing schemes generally, public and private--is being lost, and each individual payer is seeking to cut his own deal, to cut his own losses. This is especially problematic for those institutions that are dependent on an individual payer that has decided to cut its deal in a particular way.

Many of us are concerned about Alain Enthoven's plan in which the mixture of tax incentives is completely altered and the growth of prepaid plans is encouraged, but at least it is a comprehensive approach. I am concerned about the kind of system we can expect from this Hobbesian process in which each individual payer cares about its problems but not the system's. Although I do not entirely subscribe to the line of reasoning of the Health Insurance Institute's recent advertising campaign about cost shifting, it really does have a point: solving each

individual payer's problem may make every other payer's problem worse, and our institutions will be caught in the untenable position of having to make the rationing decisions, the difficult decisions about who gets into our institutions and who doesn't, on an ad hoc basis at the emergency room. That is the absolute worst position for hospitals. The solutions to this problem are not obvious; I certainly do not have any.

I think that at the grass-roots level, our industry profoundly misread Ronald Reagan. It honestly did believe that there was going to be major lifting of regulatory constraints on the industry, and through the establishment of economic competition people assumed that they were going to be free to price their services and compete in the market in such a way to ensure their survival. I think that the industry, through both the 19 percent cost increase and a record \$5.1 billion in the tax-exempt capital markets, severely depreciated its political position precisely at a time when it needed leverage to try to convince Congress to make constructive changes in financing, as opposed to changes that merely solve a short-term problem at the expense of access to care and of the survival of whole sectors of the health care system, in particular, the institutions.

The results of this Hobbesian process in which each payer is trying to cut his own deal will be a very rapid disaggregation of political interests within the hospital industry. Hospitals could very well be in a Prisoner's Dilemma situation in which a particular interest group's view of how the reimbursement system ought to be structured will result in other interest groups' being severely damaged, and as we move through this process, the escalation of individual political agendas could get pretty heavy.

I read with great interest a couple months ago the scheme proposed by the Federation of American Hospitals, the so-called prospective indemnity charge schedule proposal, which essentially capped what Medicare was going to pay in a particular market regionally adjusted and allowed institutions that had higher costs (teaching institutions, tertiary care centers) to bill patients for the difference. This is fine for the federation's hospitals, since they are relatively small institutions and are not involved in teaching and research to the extent that institutions like the University of Chicago are. But this would have resulted in our larger institutions' billing patients for those services and trying to collect, from elderly patients on fixed incomes, the difference in cost between the 100- and 200-bed institution and their own. Well, if you can't run a hospital on a mixture of water and gasoline, you can't run it on accounts receivable either. I think the American Hospital Association proposal, though it obviously needs greater refinement, was at least an effort to restrain costs without any obvious advantage or disadvantage, harm or benefit, to particular sectors within the health care system. In this process of figuring out how to spend \$3 to \$5 billion less on

Medicare, there will inevitably be a political struggle, and the leaders of these various interest groups will be challenged to not cut the deal that most sharply benefits their particular groups but instead to try to devise a proposal that achieves the fiscal outcome but is also fair and equitable.

Tom mentioned a number of roles government has played in the health care system over the years, and I think it is important to disaggregate those roles to determine where the real leverage is going to be in changing the system and in moving it toward more efficient outcomes.

He mentioned the significant role the federal government played through grants in stimulating the increase in supply of rural hospitals, in increasing health manpower, and in the growth of biomedical technology. There has also been a significant role in subsidizing health care costs and capital formation through tax exemption of private insurance, contributions by employers, and tax exemptions for bonds. This area of capital formations and stimulation of the growth of the infrastructure is, I think, the most vulnerable area in which we are operating, in addition to the financial areas Tom discussed. I think government enthusiasm for supporting continued formation of human or physical capital in the industry is nearly at an end, and we are going to have to cope with how to generate those resources from the private sector.

Government agencies have also had an enormous role in direct delivery of health services, at the federal level through the VA system, Public Health Service hospitals, and the like; at the state level through state mental hospitals; and at the local level through specialized and public hospitals. There has been an enormous and largely unrecognized reduction in the public sector's role in the direct delivery of health care. The VA system is currently operating at about two-thirds of its 1960 bed capacity, and there are signals from the VA and the Budget Office that that area will probably be receding further, so government is beginning to back out of the direct delivery of health services in a major way.

That leaves two other principal vehicles for influencing the delivery or distribution of health services: regulation--the PSRO, health planning, licensure, and, increasingly, rate review mechanisms--and the use of purchasing power--the use of those billions of federal and state dollars to leverage changes in the health care delivery system and to reduce the rate increase in health care costs.

Probably the most interesting and provocative treatment of the relative efficacy of these two methods of achieving changes, holding down cost, and improving access in the health care system is the new book by Clark Havighurst, Deregulating the Health Care Industry, which I enthusiastically recommend to people. A significant portion of the book is devoted to trying

to reprogram the health planners in the country to begin making market-based judgments about how health care ought to be allocated. Havighurst has done a magnificent job of discussing the matrix of incentives that regulation and purchase-of-services arrangements have given health care providers, and I think he has made a number of provocative and useful statements about how policymakers ought to be dealing with this problem. As you might expect, Havighurst does not believe that regulatory mechanisms have even returned the cost of the regulation, let alone achieved any significant savings--with the possible exception that rate review agencies may have slowed, at least temporarily, the rate of increase in hospital costs. He seems to be suggesting that the government policymakers (particularly in Congress, but to a lesser extent at the state level) ought to be addressing the problem of how they can structure incentives in a way that encourages meaningful competition at the nexus between providers and payers for care: that is, restructuring the regulatory system and the system of purchasing care in such a way that there is meaningful price competition at the point where care is paid for.

If I had to summarize in a global way what I think is happening to the health care financing system, public and private, in this country, I would say that it is moving in imperceptible, incremental steps toward a system of brokering care as opposed to reimbursing care on a piecework or cost-reimbursed basis. Medicaid agencies will be brokering for services with providers in the market and redirecting the flow of patients according to contractual arrangements and specific arrangements with providers in a particular market. An increasing number of employers are becoming self-insured. All of us are focusing our attention on the public sector, but there are major stresses in the private health insurance side of our industry--those wonderful people who pay us at bill charges lost a fortune last year in writing group health insurance. To expect that that side of the equation--namely, the ground rules according to which people can choose their provider and physicians, the rules which have dictated such a pathway which people take to get care--will remain unchanged is very unrealistic. Even in the AHA proposal there is an element of brokering in the provision that after a couple years, the Medicare rate in a particular market could be put out to bid, and those individuals who are not able to deliver services at the low-bid price will suddenly become unassigned providers. They would be able to bill the patient for the difference, but they would not get any guarantee of their bad debts, a capital appreciation factor, and so on.

An increasing number of private corporations are withdrawing from insurance altogether and self-funding their health benefits. The market for health insurance could be shrinking in real terms, in the number of firms that are using third-party insurance vehicles or the number of people covered under those vehicles. And increasingly, providers will be brokering with

employers, and those employers will be using their medical purchasing power to dictate the terms and conditions under which care is to be paid.

I think there is an implicit judgment here that eventually what we will sacrifice to get control of health care costs is the concept of freedom of choice.

I am not sure the American Medical Association fully realizes how many simultaneous threats there are to that basic tenet of the way in which health care is organized in this country, but I think freedom of choice, the major underlying principle of the way in which we deliver care, is going to be the first thing to go, and not only the indigent but also the "covered workers," those people whose insurance has been paid as charges in the past, are going to suffer a loss of freedom of choice. We will have to begin brokering as providers to get those patients into our system through preferred provider agreements, HMOs, closed panel arrangements for delivering care, and the like.

It is not clear to me how much of our health care system is national, either at the delivery level or the payment level, and it may well be that the only way to prevent the Hobbesian disaggregation of the payment system will be to establish, at either the state or regional level, a set of ground rules which apply to everybody, all payers and all providers. It is not clear that this approach will be equally viable in all communities. But it seems to me that solutions that look at market-based as opposed to national approaches to controlling health expenditures and rearranging the framework within which health care is purchased may ultimately be a more logical and flexible set of arrangements than those dictated from Washington. Regardless of whether Congress enacts procompetitive legislation, our institutions are going to be moving very rapidly toward a market-based model of purchasing care: a system where brokering, where competition between providers on the basis of price, will be an increasing feature of that environment.

To move on to Howard's remarks: It seems to me that this whole complex of issues--the formation of systems, hospitals diversifying into non-acute care services, corporate restructuring and the like--is part of the same process of institutions groping for frameworks within which to control their destiny, for the kinds of cooperative and, in some cases, competitive mechanisms that will assure that they will be able to remain viable.

I agree to some extent with Howard's premise that much of the development of these systems, and here I am thinking particularly of the National Alliances, are adaptive responses to threatening changes in the market. The growth of the for-profit systems has been intensely threatening, not only to the concept of not-for-profit or voluntary hospitals but also to the



concept of local control over health care resources. However, I do not view the growth of the hospital management firms as an adaptive response at all; rather, I believe it is the aggressive adoption of a corporate vehicle for organizing health services, and it may be a new way of coordinating and rationalizing resources. So while there is an adaptive dimension to the way in which hospitals are responding, there is also a proactive, strategic dimension to the way in which hospitals are organizing and sorting out institutions. Which of these organizations have been formed merely to react, merely to provide some kind of framework for fending off incursions of other systems, and which have been formed with the explicit strategic mandate for organizing and controlling the delivery of care is a key question in our evaluation of these systems.

There are purists who use the word "system" to describe things that function as systems. There is a great deal of variation in the extent to which either multihospital systems or systems of systems ("supersystems") are behaving like "systems." It is not clear to me that a lot of the religious systems are systems in the functional sense, in the same way that an HCA or an Inter-Mountain Health Care is. Several questions arise, such as, is this a corporate enterprise? Is there a corporate strategy that results in certain kinds of behavior and management imperatives inside the system?

I think there is a regional versus national issue here, too. I wonder whether there is a national market for health services or a viable national modus operandi for health management. I have looked at a number of so-called national referral centers--the Mayo Clinic, the Cleveland Clinic, and, most recently, the Texas Medical Center--and the signs in all of these areas are that their share of the national market is shrinking and they are becoming increasingly regionally dependent systems. Perhaps the national framework of organizing health services is not viable. I think that the market in this country is not a national market but a collection of regional markets, and the ultimate struggle for control over health resources will be fought at the regional level. There is a powerful movement in this direction at HCA, which has just decided, after growing to a certain level, that it is no longer realistic to continue to manage 350-400 hospitals centrally from Nashville. In fact, HCA has split into an eastern and a western region, and even within the western region, HCA is going to develop market-based strategies for organizing its holdings and relating those resources clinically and administratively at the individual market level.

Although there are national aspects to our system, such as the Medicare program, capital markets, organization of private insurance firms, Prudential, and so on, I think the real locus of control of health resources is at the regional level--for market purposes as well as financing purposes.

In terms of the various functions and project functions of systems, I happen to think that one of the most powerful of them is one that Howard mentioned: the notion of diffusion of technological competence and innovation. One of the things that I believe that alliances can do best is to duplicate or replicate very rapidly successful experiments that have been conducted in particular markets. In other words, within the United Health Care System (UHS), if it becomes clear that the preferred provider organization (PPO) that John Casey (of Presbyterian/St. Luke) has developed out in Denver is an effective vehicle for organizing physicians and hospitals to begin brokering for self-insured employer business, UHS could serve as a vehicle for replicating that PPO in other markets very quickly without having to go through the process of hiring separate consultants and doing separate studies that inevitably result when hospitals try to adapt and develop new forms of delivering care. This rapid diffusion of innovation and bright ideas is one of the single most powerful benefits of system formation, and it is being exploited very effectively by several of the national investor-owned firms as well.

On the issue of capital formation, I wonder whether the whole is going to turn out to be greater than the sum of its parts. It may be true that the organizations that rate bonds and market securities tend to view these multihospital systems as better credit risks and their securities as more marketable securities, but look at the organizations they are talking about: Inter-Mountain Health Care is a powerhouse financially, organizationally, and in about every other way. The extent to which the system has caused that aggregation of strong hospitals to be more marketable remains to be demonstrated. Many of these systems have been built from core hospitals which were financially powerful to begin with. The real test of this alliance notion is whether the appropriate vehicle can be found to harness the separate capital formation powers of the individual institutions to achieve a more favorable outcome, either a broader base for capital formation or a lower cost of capital.

The fact that there continues to be little demonstrable evidence of the ability of systems to integrate clinical services is deeply disturbing because I agree with Howard and others that this is ultimately where the savings are. However, to do that, systems must figure out a way to encourage the physician to participate in the system activities; it is far from clear that they have been able to do so effectively to this point or that the physicians' input is considered important. The anxiety in organized medicine about the growth of these multihospital organizations and the development of these diversified corporate structures is palpable. A number of resolutions in last year's AMA House of Delegates meeting were concerned about investigating these systems because of the fear that they might erode the power of physicians to determine and supervise the quality of care. At the Federation of American

Hospitals' meeting back in February, three representatives of the Associated Hospital Systems gave presentations about their individual corporate strategies. Not a single one of them mentioned the physician in their hour-and-a-half discussion. However, as Howard said, systems will have to figure out a way to make it in the physician's interests to participate in those types of shared services and clinical arrangements, or we are not going to see any significant evidence of clinical consolidation or the use of these systems to eliminate the duplication of services.

On the cost and economic impact, there continues to be at best equivocal evidence that systems have been able to bring down the overall cost of care, though there have been a number of proprietarily financed studies on whether the nonprofit systems are cheaper than the for-profit systems. It's really a heavyweight boxing match between some of our country's more talented management consultants. I wonder if we are going to see a significant economic impact as a result of these until this brokering process of which I spoke begins to take hold in a major way.

The area in which I think there is the greatest potential for possible system benefits--and on this there is almost no published research--is the area of the impact of market penetration or market share on the profitability of the enterprise. As those of you who have studied strategic marketing in business school know, there is a powerful positive linear relationship between market share and profitability measured as return on invested capital in most of the nations' industries. Booz, Allen and Hamilton's as yet unpublished research on the relative profitability of regional systems according to market penetration suggests that similar positive relationship exists within the hospital industry. If this is so, control over local markets through both horizontal and vertical integration may become one of the key aspects of the struggle for capital that hospitals will be engaged in over the next ten to fifteen years.

Much anecdotal evidence I have come across in my travels around the country suggests that in such specialized areas as pediatric care, share of the market has a good deal to do with whether the institution is running in the red or black. So I think the use of the multihospital system as a vehicle for locking up and controlling markets (again, at the regional level) may have an enormous bearing on the viability and meaningfulness of these enterprises in the future.

In addition, the use of the multihospital system as a vehicle for aggregating both political and professional power in the health care and hospital industries may be an important by-product and consequence of multihospital organization. Maybe the Voluntary Hospital Association, UHS, and the Sun Alliance really are the next generation of HRDI (Hospital Research and

Development Institute) vehicles for bringing together industry leaders for sharing ideas and swapping both benefits from those ideas and ways of leveraging one person's knowledge and the knowledge that is broader, that may be applied to multiple markets. These are important enterprises, and there is a lot of information being exchanged within the alliances that may redound to the benefit of those participating hospitals in ways that are not immediately or empirically measurable.

On the research issues, it seems to me that the research in the multihospital systems field has been focused largely on issues of taxonomy and the economic and functional benefits that accrue from organization. There is another dimension of the multihospital system that I would like to see explored in some systematic way, and that is what I call, for want of a better expression, the ethnographic dimension. What aspects of leadership style and the organization of medical practice in a particular community or region and what aspects of the organization of political and medical elites in a community result in the effective development of these multihospital organizations? How do the characteristics and competitive aspects of various markets in different parts of the country affect the incentives to create multihospital organizations? We can learn a lot from studying the multihospital system in its markets and viewing the multihospital movement as an effort by organizations to control their destiny within those markets. I would like to explore that a little bit in our discussions.

CHAIRMAN ANDERSEN: Perhaps Tom or Howard would like to respond briefly.

C. THOMAS SMITH: I do not have anything to add to what Jeff said. I just echo his comments that everybody is interested in the question of whether federal policy developments or private purchasers of care are changing something about the system.

DR. ZUCKERMAN: As always, I am impressed with Jeff's comments, and I am interested in the question of the appropriate focus of research. In the Associated Hospital Systems Research Project that I mentioned earlier, we are trying to develop not only a set of performance indicators but also a fairly elaborate collection of information and data about the systems along a number of dimensions: the organization's corporate management structure, legal structure, market share, and planning and budgeting processes, and the nature of services that are aligned to businesses in which they are involved. We are attempting to develop a profile of each of these systems, and then we plan to attach the performance indicators to those, with the underlying question being, Can we understand enough about what these organizations are structurally, how they work in the areas in which they are located, and the implications of those two issues to their performance?

## HOSPITAL REIMBURSEMENT CONSORTIUM

Donna I. Regenstreif

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The second session of the Twenty-fourth Annual George Bugbee Symposium on Hospital Affairs convened at 1:45 P.M. with Richard W. Foster presiding.

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CHAIRMAN RICHARD W. FOSTER: We heard this morning some conflicting views on the motivation for formation of multiinstitutional arrangements. We heard a more varied account of possible facts about multiinstitutional arrangements and even a little bit of evidence on a few of them. The stage is well set for the next three presentations in which we will learn about three very innovative entities. The first is the Rochester Area Hospitals' Corporation (RAHC)--which, I gather from the previous discussions, is not a multiinstitutional system according to the AHA because it does not, in fact, own, lease, or contract to manage hospitals.

Nevertheless, the speakers from this morning seem to agree that changes in the environment, and especially in reimbursement, were important forces motivating the establishment of multiinstitutional arrangements, and RAHC is rare, if not unique, among multiinstitutional arrangements in directly addressing the reimbursement problem.

We are pleased to have with us from RAHC the executive vice-president, Donna Regenstreif.

DONNA I. REGENSTREIF: I am very pleased to be here and honored to have the opportunity to address this very famous group.

As you have heard this morning from Mr. Smith and Mr. Zuckerman, a variety of fiscal and regulatory constraints have been building in the environment, and I think in New York State perhaps we experienced them a little bit sooner than the rest of the nation. So the fact that we are where we are today is as much testimony to our location in the state of New York as your interest in this topic is to the fact that it is becoming a national problem.

You are all aware of the New York City fiscal crisis and the implications of that for the state. Starting in 1975 and 1976, very rigorous cost-containment policies that limited payments to hospitals--first for Medicaid, then for Blue Cross, and eventually for charge-paying patients as well--resulted in a very serious threat to the solvency of hospitals throughout New York State. This occurred despite the fact that in Rochester we felt that we had a basic level of economy in our local health

care system, particularly in the hospital component of that health care system.

Prior to our Hospital Experimental Payments (HEP) Program, payment mechanisms for all hospitals in the state were under government regulations that were often contradictory and that did not permit hospitals to manage because income prediction was impossible. Invariably hospital administrators would find that they lost revenue in accordance with any cost reductions that they succeeded in achieving. That is not exactly a salutary position for a good manager. Hospital administrators felt great frustration in their efforts to establish policies that could simultaneously enhance patient care and maintain financial solvency for their institutions. Their ability to budget and to plan effectively was adversely affected by frequent changes in reimbursement rules and in regulations. By 1978, hospitals in Rochester and elsewhere in the state had already begun to liquidate portions of their endowment to underwrite routine activities. In talks this morning you heard statistics and commentary on the national back-drop to rising costs. I would like to briefly review some of these facts. Consider the growth curve of the health sector of our economy over time since 1950. At that time health was about 5 percent of Gross National Product (GNP), and by 1978-79 it had reached 8.5 percent and was climbing somewhat exponentially. At that rate we would soon reach a point where 10 to 15 percent of the GNP could be allocated to health, particularly with our increasingly aged demographic picture, and the continuation of this rate of growth is regarded by most as politically unacceptable.

Some background would be helpful here. According to the health sector growth curve that shows national health expenditures as a percentage of GNP, around 1960, health expenditures were about 5.2 percent of GNP, and around 1978, the portion had risen to 8.5. Now we are climbing to about 10, 12, 15 percent of GNP. In Rochester we are trying to get away from this exponential rate of growth and into a slower, steadier growth rate which is more reflective of inflationary trends and planned increases in needed services for the changing population of the community we serve. This has essentially been achieved by New York State and is being sought by the other northeastern states that have relatively tight regulation of their reimbursement systems. We have tried to provide a responsible, community-based voluntary alternative to what must necessarily be less sensitive state-wide regulatory modalities.

In Rochester in 1966 there was an advertisement in which we all took great pride. Each year Blue Cross and Blue Shield would report to the community and show what the community's investment in hospital care, via Blue Cross premiums and other payments, was purchasing. It showed that in 1966 we had spent \$36 million, and that in that twelve-month period, apparently all of these different products were produced: We admitted 84,000 people. We cared for, prepared, delivered, and received

an enormous variety of X-rays and lab tests, visits to the emergency department and to other outpatient areas, and so on. Once again, the total cost to hospitals for health care during this twelve-month period was \$36 million. And more than 53 percent of it, this ad informs the evening paper readership, was paid for by Blue Cross-Blue Shield.

Now this was 1966. By 1980, Rochester hospitals' trustees were facing a very different situation. Despite the fact that the community's history of planning, which dated back to 1940, had resulted in a bed-to-population ratio of 3.4 per 1,000, in Blue Cross utilization rates of about 500-550 days per 1,000, and in Medicare utilization rates that were around the national average of about 3,400, the rigorous state regulatory system was seriously threatening the solvency of the hospital industry. The hospitals' trustees felt that they needed to come up with a positive alternative. The RAHC trustees, the trustees of all of the hospitals in the Rochester area, determined that they would develop a local system of self-control. You have heard this morning that apparently the only alternatives presently being considered by the federal government are regulation or competition. Self-control is perhaps a variation on both these themes. Recognizing that, particularly with the number of public dollars and public beneficiaries involved, it is impossible to do without any control and accountability. We felt that a system of self-control or contractual arrangement among the hospital industry, the payers, and the community was perhaps the best way to go.

The Rochester Area Hospitals' Corporation was incorporated as a not-for-profit organization in July 1978, after years of less formal kinds of cooperative planning efforts among the area hospitals, their administrations, boards, and medical staffs.

The initial task of RAHC was to develop a payment alternative that would be able to test the assumption that the community could indeed, through a system of voluntary local control and accountability, both improve the solvency of the area's hospitals and provide positive incentives for cost effectiveness. To reiterate, RAHC's multiple missions were to: maintain and enhance the community's hospital system, control the rate of cost increase of hospital services--thereby insuring the availability of needed services in an era of increasingly constrained services--facilitate local decision making, and maximize the cost effectiveness of the hospital services.

The HEP program was developed to accomplish these goals in concert with the RAHC administrative structure and process. A contract was developed specifying the terms for a new hospital payment methodology that consisted of a prospectively determined community-wide cap on revenue for a three-year period which began January 1, 1980, and during the first year was extended through December 31, 1984. It was signed by RAHC, as the multihospital consortium representing the hospitals in the

negotiations between the community's hospital industry and the major payers of hospital bills. It was signed by all of the hospitals in our nine-county area, and by the three contracting payers to the payment experiment--Blue Cross, Medicare, and Medicaid. These payers together underwrite about 85 percent of local hospital expenses.

The nine hospitals participate in RAHC through a rather complex committee structure. The hospitals range from a 100-bed, semirural-type hospital of which Lakeside Memorial and Noyes Memorial are examples, to a tertiary-care teaching hospital, namely, Strong Memorial Hospital affiliated with the University of Rochester, which is the teaching hospital of the University of Rochester School of Medicine. These hospitals collectively employ some 10,000 people, and they annually train more than 600 residents in a variety of medical education programs. They constitute the northern subarea of the Finger Lakes Health Systems Agency.

RAHC is a membership corporation, with the nine area hospitals as its members. It has a board with two trustees from each hospital plus two from the University of Rochester School of Medicine. The RAHC Administration Committee consists of the chief executive of each member hospital; the Medical Advisory Committee consists of two physicians from each participating hospital; and the Financial Director's Committee includes the chief financial officers from each hospital. At first, when HEP details were being developed, the Financial Director's Committee was one of our busiest. Since the HEP program began, the board's Finance Committee, which consists of the head of each hospital board's Finance Committee, have become increasingly active in the committee structure surrounding the implementation of the payment experiment.

So, to return to figures which we have reviewed for 1966, just before Medicare and Medicaid were implemented, we had a \$36 million hospital system in Rochester, and our community was extremely proud of it. In 1980, when HEP began, that had become a \$275 million hospital system, and there were relatively few people who could really explain and justify the factors which had caused that cost escalation.

I will now try to describe what has happened under HEP during its first two years and how this has been accomplished. In 1977 for U.S. hospitals, there had been a 14 percent cost increase over the previous year. In New York, the percentage increase was beginning to show the results of extremely tight rate regulation on the part of the government. In 1978 and 1979, nationwide the rate of cost increase of hospitals came down a little bit. Figures for Rochester and New York State hospitals still were running more or less in tandem during these years just prior to the beginning of HEP. In 1980, the first year under HEP, there was considerable success on the part of both New York State and Rochester hospitals in containing expenses



relative to the nationwide pattern for hospitals, and even below the rate of general economic inflation as measured by the Consumer Price Index. Then in 1981 there was a decline in the CPI, continued escalation in the hospital sector nationwide, and relatively greater cost containment success on the part of Rochester hospitals operating under the voluntary HEP system than New York State hospitals experienced under a regulatory system. The cost increase figures are 18.7 percent nationwide, 12 percent in New York State, and 10 percent in Rochester. Rochester hospitals were about the only ones in the state which showed any improvements in their financial condition as well.

How did we manage to do this? Essentially by developing a reimbursement system to promote effectiveness and efficiency in the delivery of hospital services in the area. HEP is predicated on the assumption that a major cause of inflation in hospital costs has to do with the faulty design of hospital payment systems. The inherent incentives in traditional payment systems both nationally and in New York State are contradictory, are often extremely punitive, and do not promote the rational delivery of needed care as economically as possible. HEP encourages hospital cost containment through the introduction of what we regard as positive financial incentives in the hospital financing system which affect both inpatient and outpatient services.

The new incentives are, for the most part, the result of two features of the system: the payments for each hospital are based, after the first year of the program, on that hospital's preceding year's payments without regard to its incurred costs, and cost savings realized by the hospital accrue to its benefit throughout the period of the program. In addition, approximately 2 percent of each year's payments to hospitals is made available for new services, volume adjustments, and special projects related to the HEP program. As you are aware, these features are highly unusual. Results thus far show a containment of cost increase that is considerably at variance with what many people thought would happen, given common assumptions about the nature of the hospital industry and the economics of medical care. Indeed this result bewildered some people because many people in the health reimbursement and regulatory agencies are quite convinced that if you gave a hospital more money, it would only spend it. Here we were, guaranteeing certain levels of revenue to hospitals and discovering, that somehow or other, even though they did not directly control many factors affecting costs, they managed to control cost increases extremely well.

The two principal causes of hospital cost inflation that are addressed by the HEP program are what we can refer to as the volume problem and the planning problem. The volume problem relates to the fact that incentives of traditional reimbursement reward high rates of admission, long lengths of stay, and increasing resource use (otherwise known as "intensity") per

admission. The planning problem is that planning agencies, even where there is tight certificate-of-need (CON) regulation or linkage between health planning and reimbursement agencies, have not typically achieved an accurate assessment of the financial reasonableness of new projects, nor have there been effective links of projections of expenses to subsequent payment levels. One's project may be approved up to five years ahead of implementation based on certain financial assumptions, and the final system does not hold sponsoring institutions accountable, fiscally, to these projections in any very rigorous way.

HEP's response to each of these issues is diverse and very clearly delineated. Concerning volume, hospitals are compensated for increases in inpatient admissions according to a formula that is designed to discourage marginal admissions, to reduce lengths of stay, and to promote increased use of more economical outpatient services. All payment for additional services is drawn from a single community-wide contingency fund so that hospital administrators are collectively at risk for unwarranted increases in volumes of services. Furthermore, there is a 2 percent corridor before increased admissions are paid for, and a very conservative marginal cost factor of 40 percent applied to payments for inpatient admission increases beyond the 2 percent corridor.

The planning problem is addressed by contractual provisions for new services. The operating costs of CON projects proposed by RAHC hospitals are reviewed both clinically and financially and related to community need. Payments for incremental expenses of such new services are likewise drawn from a community-wide contingency fund, so they are constrained. In effect, we have a zero-sum game at work in the Rochester area, and the costs that are approved are subject to negotiation between both the RAHC financial staff and the hospital financial staff, as well as to collective display and review of those incremental costs among all of the hospitals' finance people, at the level of administration and board. So the hospitals are collectively at risk for the associated costs of these decisions, and there is both the expertise and the incentive to improve cost effectiveness.

HEP computes each hospital's allowable cost base, based on its 1978 allowable costs defined in accordance with medicare payment principles. We used 1978 because those costs were the most recent audited figures available to us in 1979 when we were developing the program, which was proposed to be implemented in 1980. The calculations done on that final allowable cost base, which is 1978 actual, involved adding a trend factor percentage to compensate the hospital for inflationary increases in the particular market basket of goods and services consumed by it each year from the base year (1978) to the rate year (1980 and thereafter). The HEP contract provided for an additional 1 percent on top of that in 1979 and 1980 for needed working capital.

On a community-wide basis, all of the individual hospitals' allowable cost bases were added together, and 2 percent of this sum was made available in a community-wide contingency fund to pay for new services and technology, volume adjustments, etc. The final aggregate dollar amount available throughout the industry for 1980 was some \$280 million. The contingency fund is maintained by RAHC and is paid out based on both contractual obligations and decisions of the board, based upon the rather complicated process of clinical and financial review which I described earlier.

What are the types of hospital products that we are buying for this \$280 million? Let us take, for example, laboratory tests. A routine maternity admission, in terms of laboratory tests, increased threefold between 1951 and 1971, and that was only the hospital component, not the preadmission increase and ultrasounds and a variety of other kinds of diagnostic and treatment entities prior to admission to the hospital. The same sort of pattern relates to a wide range of common and uncommon admissions. (See A. Scitovsky and N. McCall, Changes in the Costs of Treatment of Selected Illnesses 1951-1964-1971, DHEW Pub. No. [HRA] 77-3161 [Washington, D.C.: Government Printing Office, 1976].) At the macro-hospital level, from 1977 to 1982, which is just a five-year period, there has been a doubling in both the number of laboratory tests and the costs of tests. Moreover, the cost of tests done in hospital laboratories was \$1 billion, while capital equipment expenditures were of the order of \$600 million. You can see that both the capital financing and the utilization issues are very clearly delineated in this kind of experience.

Now what about control over these costs? Presumably we set in motion a reimbursement experiment that gave hospitals the ball within a whole new game, with whole new rules. How were they suddenly able to switch gears and change from a system of incentives that pushed them in one direction to one that went in a very different direction? Clearly, new kinds of coaching skills were required to play this game.

First we decided to figure out the relationships among the key factors in hospital costs. Let's take patient cost in a hypothetical \$20 million hospital. This cost is a function of the number of admissions (10,000), times the average cost per admission (\$2,000). The average cost per admission is a function of the average length of stay (7 days) multiplied by the average daily service cost (\$160 per day) added to the average number of ancillary units, bandages, drugs, supplies, respiration therapies, inhalation therapies, EKGs, and the other items consumed in the course of treating an episode (approximately 42 units) times the average cost per ancillary unit (approximately \$15). The resulting sum is the \$20 million inpatient expenses.

What about control over this? Some of the preceding items are controlled, theoretically, by the hospital management, while others are controlled by the medical staff or other agents. It became apparent very rapidly to us that anyone who talks about cost containment or management as something that involves only hospital administrations or insurance companies without looking at clinical practice, without looking at the physician side or the supply of hospital services is clearly addressing only part of the problem. The scale cannot be balanced if leverage can be applied to only one or the other side. One can totally control the rate of increase in cost of services, but without control over utilization in some rational way, the cost problem remains. In order to move toward more rational overall management we needed to have better data and new types of analyses of this newly available information.

First we developed a methodology to better understand our hospitals' expenses. The financial analyses that we conducted during 1980 represented an effort to display hospital cost patterns in the 1978 base year and to provide a comparative context of other hospitals in Rochester and elsewhere. We happened to use Maryland because they had the best financial data base for a comparative analysis of financial cost. We also thought that we should do some clinical analyses to help hospitals understand the types of medical care, or hospital products, that they were delivering. We recognized that we needed to create a single language, a common language, that could be spoken by physicians, board members, trustees, and financial people and that would enable major dialogue among these components of the hospital community. If all were part of the problem, they were all needed to facilitate the hospitals' solutions.

The traditional kind of report on a hospital's product that people are used to examining at the board level is the audit report. This type of report indicates whether the hospital has done what it claims to have done and describes how it spent its money. We tried to develop a data base that would enable a very different sort of aggregation of information and action based on that aggregation. The data base includes medical abstract data, patient billing data, financial and statistical utilization information, and wage and salary survey data, so we could distinguish between utilization function expense, production function expense, and so on. The types of reports that one can glean from such a data base include a variety of displays of cost and case mix kinds of issues, or diagnosis-regulated groupings (DRGs)--and at the time we began our data base, they were pretty well accepted as the best, if not the ideal, groupings of clinically homogeneous types of patient care episodes, sometimes referred to as case mix.

Since 1980, when we began this, we have joined in efforts to develop better clinical groups. DRGs, although they supposedly group patients who are relatively homogeneous in their patterns

of hospital resource consumption, do not really enable that information to be translated into the clinical management structure of a hospital. There are various DRGs that include both surgical and medical patients, or cardiological and renal patients, and so on. There is also some lumping of patients with different levels of severity or stages of advancement of their disease.

Our refinement efforts involve trying to provide additional case grouping capability so that the chief of a department of medicine or the chief of the GI unit can have a better perspective on patterns of production within each clinical area of the hospital. We are trying to give each hospital management team better information to enable follow-up on areas which may yield improvement in patient care quality or cost effectiveness. This same type of analysis can be applied to outpatient activity and other types of hospital products. This orientation to analysis of the effectiveness of hospital care is by no means revolutionary. The earliest explicit reference which we have found to a need to move in this analytic direction goes back to 1913. We understand that Dr. Codman, who talked about "the product of hospital" before the Philadelphia Medical Society in 1913, subsequently was relieved of his position at the Massachusetts General Hospital. We believe that the time is ripe to put some of his concepts into action.

What are some of the things that we have learned during the first two years of our experiment? One phenomenon is that we are seeing an enlarged role for hospitals in the community's health care system. For example, the issues of effectiveness and efficiency of hospitals immediately become linked to effectiveness and efficiency of other components of the health care delivery capability in the community. Are the preventive programs working well, or the ambulatory treatments and diagnostic programs operating sufficiently? Is the hospital able to move its patients, who represent completed products, out when the time for discharge comes, or does it suffer from patient care backup because of problems in the long-term care system? These are some of the types of questions in which we have become extremely involved. The issues involve both "vertical" and horizontal coordination of the health system.

Another thing that has come into focus is that the structure of the hospital brings together the business leadership, the medical staff and the medical community, and generally the major health care administrative and clinical expertise and wisdom around a single organizational structural entity. We have seen hospitals becoming much more proactive in capitalizing on that strength in meeting a broader range of challenges.

Finally, we have quite an education and research agenda, which is concerned with developing better outcome and quality effectiveness measures, studies of clinical resource use patterns, including shifts and variations in these patterns, and

applying these new elements of knowledge to hospital administration and in training of tomorrow's administration and clinical managers. We are also conducting an overall organizational evaluation through the Institute for Social Research at the University of Michigan.

I'm sure you can tell that we are excited about the things that are happening in Rochester. The demonstration nature of our program is such that we say more often: "Wish we had thought of this or that," than simply taking this or that hospital success for granted and assuming it will continue without further understanding or assistance. We are looking forward to the coming years when we expect we will have been up and running long enough to be able not only to see more change but to have a better understanding of it.

If there is time for questions, I would be happy to try to answer some of them.

DONALD W. CORDES: I am interested in the ways in which this might be helpful to a hospital that had a difficult negotiation problem with hospital-based physicians. Did this tend to help hospitals level out the compensation for pathologists, radiologists, anesthesiologists, and so on?

DR. REGENSTREIF: It has not yet had that sort of impact. In Rochester there has been a tendency since 1977 for radiologists to leave hospital umbrella billing mechanisms, and that has continued. About three hospitals had done that prior to our program and two more did it under our program.

On the other hand, some oncologic activity has come under the umbrella of the hospital. If pathology, anesthesiology, or radiology arrangements have changed significantly in any way that can be linked causally to the experiment, I am not aware of them.

PETER WEIL: You mentioned something about an amount that is paid to the hospitals in one year, paid to them identically the next year. Is that the way you save money?

DR. REGENSTREIF: There is an amount paid to the hospital each year. This amount is rebated to the historical costs for their activities in 1978. That amount is broken up into its component costs, such as medical supplies, pharmaceuticals, labor, and so on. There is a separate trend factor applied to each of those components of each hospital's costs. To that is added whatever approved costs have been provided to them for new services in the intervening year, and the total amount is projected and paid to them prospectively the following year.

So that is the revenue side. This is not an expense account; expense accounts have never worked. What we have done is put a community-wide ceiling on revenue and guaranteed a hospital its

revenue floor. We have put in place a variety of processes which are intended to enhance opportunities for effective operation between that floor and ceiling.

MICHAEL J. EBERHARD: What has been the effect on the hospital's profit margin?

DR. REGENSTREIF: The profitability of hospitals has improved significantly, but this is not to imply that it approaches industry standards nationwide. This was accomplished in part because they are under a prospective payment system here, so the cash flow has increased. Therefore, their debt service obligations in an era of high interest rates have dramatically decreased the expense side and improved the revenue side.

So the cash flow effect is one which was seen primarily as a one-time benefit in 1980 over 1979. We think the more predictable fiscal environment under HEP has also enabled managers to improve their hospitals' financial conditions. I am not aware of any significant change in the relationship of nonoperating revenues to expenses.

MEMBER: You mentioned that Medicare/Medicaid and Blue Cross are participating in this plan. How do revenues from other sources, say private payers or private insurance companies, get accounted for? Are they part of the cap?

DR. REGENSTREIF: Yes, they are part of the overall revenue cap, but they do not behave differently than they did prior to HEP.

About 15 percent of total costs are what we call noncontracting payer. Let us say we have a \$100 million pie. Each of the contracting payers (Blue Cross, Medicare, and Medicaid) is apportioned its liabilities based on the proportion of use of services by its beneficiaries. This 15 percent is subject to the same apportionment procedure except that the hospital sends out bills for that, and collections for those charges must cover whatever expenses are left to be covered in that sector. To the extent that bad debts are incurred in this area, collections for charges are the only additional source of revenue to cover these expenses. We feel this is a flaw in the program but we were only able to make progress incrementally. We could not turn the reimbursement system upside down overnight. We would certainly try to make some improvements in this area in the future. Each hospital is only allowed to keep its revenue up to that ceiling. After that, excess collections go into the contingency fund and thus there is an effective constraint on overall revenue.

JEFF GOLDSMITH: I am still not clear on how the private insurance revenues are dealt with. Are excess revenues collected from private insurance put into the fund? Does the excess of revenues over average cost or cap cost represent net

income to the hospital system?

DR. REGENSTREIF: The net income to the hospital is represented by the difference between revenue and cost and therefore is subject to each hospital's effectiveness in cost containment because their revenues from all of the contracting payers are guaranteed. The charge-paying revenues are subject to whatever basis the hospital has used historically to set its charges.

DR. GOLDSMITH: So it is possible that a significant percentage of a hospital's net income under your system is coming from those private insurers who are operating outside of your system?

DR. REGENSTREIF: No, it isn't. No hospital that I am aware of in the first two years of the program through 1981 managed to collect monies from that 15 percent sector of its charges to cover even the costs incurred in that area. Most of the noncontracting payer activity is outpatient activity, which has limited insurance coverage. Much noncontracting payer activity is self-pay rather than other insurance so there is significant bad debt potential. These factors vary considerably for each hospital.

GARY MECKLENBURG: I am curious what the capital spending pattern has been over the first couple years of your experience. You have had very impressive trend lines in terms of expenses, but that could be seriously affected by diminished capital expenditures. As I recall, there was major construction in Rochester in the 1970s right before the project started, so do you have any data in terms of the impact of capital activity during this period of time you are talking about?

DR. REGENSTREIF: There has not, in 1980 and 1981, been significantly increased capital expense. Capital is treated as a pass-through under the experiment. Major renovation will result in some cost increase bumps from year to year as new projects come on line, but this has not occurred thus far. We are just beginning to try to do something about these issues, both through community-wide capital planning process as well as better contractual treatment of capital expenses, but it is still much too early to say how these efforts will take shape.



## VOLUNTARY HOSPITALS AND MULTIHOSPITAL ACTIVITIES

Don L. Arnwine

CHAIRMAN RICHARD W. FOSTER: Our next speaker is the president of the Voluntary Hospitals of America (VHA). Don Arnwine was president of one of the members of VHA immediately before committing himself more fully to that organization, and it is a great pleasure to have him with us.

DON L. ARNWINE: I would like to congratulate those who planned this outstanding conference because, as you might suspect, being identified with a systemization of this industry, I have been invited to many conferences over the past month, and I must say very sincerely that the collection of people that you have here and their insights have been notable.

I would also be remiss if I did not congratulate and express admiration to George Bugbee for the contributions he has made to this field. I believe very much in the acceptance of a perspective, and while we are here dealing with what might even be a phenomenon, it is really just a part of an evolutionary process, and we have all been very much affected by our history and by those who have contributed to it.

In large measure we are dealing today with experiments of various kinds. I think they are interesting. I think they are hopeful. I think some will be bound to stick and some will not. But one of the great joys to me after having labored in this vineyard for so many years is a new attitude that I sense, a positiveness about the future that I think most of us did not have five, six, or ten years ago. For a long time we felt that things were occurring at a rapid, breathtaking pace and that surely none of our forebears had experienced that pace of change or any of the burdens we were having to experience. And we even went through a period in which we wondered if there was a qualitative future for this business. I think we knew that our services and institutions would be needed, but we wondered if the quality of the services provided would not be diminished to such an extent that we would find them unacceptable.

What we are being exposed to here and elsewhere in this environment is a new attitude, a realization that it is possible to be more than just victims of our environment--it is possible to participate in creating the elements of that environment. That is one of the reasons I am so enthused about what is occurring. What the long-term impact will be, I do not know, but I do know that out of this will come some new patterns, some new things that will benefit this society because we have stirred things up.

The segment of this systemization process that I represent, the voluntary systems, does not fit any of the AHA definitions. Maybe there is no definition for it up to this point, and maybe

eventually there will be, but I am pleased that the planners of this conference recognized that what we think of and speak of as voluntary systems is really a part of what is occurring today and is related to the kinds of systems that are covered under the definitions that have been adopted.

While I cannot speak for the other voluntary type systems, such as Associated Hospitals Systems (AHS), United Health Care Systems, and the Sun Alliance, I think that the exploration of this type of coming together is germane to those other kinds of systems. I will be speaking more specifically about VHA, of course, but also with reference to the supersystems.

Whether the supersystem means anything in the long run, it means something today, because people in this field and observers of the field are interested in this development. I think the supersystem represents a quantum jump in the evolutionary process that began with sharing of services and collaborative efforts. The jump was taken because of new knowledge and new pressures, a knowledge about how to use the existing laws and processes in this society to create something that might have some prospects.

As I said, people are interested in these systems. For example, over just the past several weeks I received two or three inquiries per week from institutions which want to find out more about VHA and are interested in becoming a part of it. We have contacts and are working in one degree or another with a variety of groups who are interested in evaluating what we are doing. We are in contact with a fairly large religious group of hospitals. We are in contact with a group of twenty-one rural hospitals that are interested in creating a rural system. We are in contact with a smaller rural group of institutions and with another group that is a mixture of rural and urban institutions. We are communicating with two groups of mostly urban institutions, a group practice group, a group of CEOs of large group practices who have been meeting together for various reasons over the years and now want to explore making it something more meaningful, and a group of CEOs of specialty hospitals. (Actually they are psychiatric hospitals that want to explore the possibility of putting together a little specialty system on a voluntary basis.) So whatever that means in the long term, I do think it means something today, because out of interest often comes action, and that may well portend one of the kinds of reshaping that is taking place in the industry.

There is no question that our industry is being reshaped today, and any time that you see something being remolded or reshaped, you know that there is some force causing it, some driving force or forces that is either pushing it or pulling it into a new shape. The reshaping also takes place because people are either responding to the force or are trying to get out in front of it.

I would like to talk a little bit about what has brought us to the present point. I would also like to identify the ingredients, the advantages that we see within this kind of development, and then I will talk more specifically about VHA.

If you want to know what shaped this industry historically, in my opinion the principal driving force was one that we might call a theological force or a social force. It was to say that we are our brother's keeper and have a responsibility to our fellowman, and this was manifested by religious groups getting involved in the health care industry, particularly the hospital sector, or community groups getting involved in and pursuing the development, creation, and maintenance of an institution for the same altruistic purposes and social concerns. I think that next in importance as a driving force in our industry was science and technology. Our increasing knowledge of medicine, of how to care for people, was added to the armamentarium and tended to create a different shape for the hospital sector and the industry at large. In addition to these were the political forces, which have always been prevalent, particularly in this country, and those have been exercised at the municipal, county, state, and federal levels. Probably the single most political act was the Hill-Burton program, which probably did more as a political act to reshape the hospital sector than any other one thing. Next in magnitude of influence on our industry was the force of knowledge of institutional management. As programs such as the University of Chicago's and others came into being to train people as professionals, that knowledge began to make an impact and tended to change the character and shape of the hospitals and the industry. Finally we have, of course, the economic force, which is always present in any industry, but it has not been that prevalent or that persuasive in this industry.

However, today, because of a variety of developments nationwide and worldwide, the order of importance of these influences has been reversed, and unquestionably it is the economic forces that are paramount in causing the reshaping of the system. What we are talking about here is either a response to economics or a proactive action because of it. We see individual institutions going through restructuring processes. Institutions are reaching out and embracing other institutions, diversifying, broadening their missions--all of the things that have been talked about. We used to think of simply the sick care sector: somebody who was ill or injured came in the door and we took them; when they left, we didn't worry about them. Now we see institutions embracing wellness as well as sickness, and the full range of activities from birth to death. We see the phenomenon of marketing. Ten years ago if any one of you had created a marketing department in your institution, you would have been sent off to the funny farm.

All of these things are institutional responses, and there is no question in my mind that the economic force is prompting these responses. And all of this is causing a coming together

in a variety of ways and for a variety of purposes, for example, seeking investment, seeking survival. The coming together is also happening because, given those environmental factors, logic seems to say to most people that group action can be most effective or at least be more effective. That is, group action can be more effective if it is properly controlled, well organized, and professionally led.

I want to make a comment about the quest for survival. I do not think that survival is really what most of us in this segment of systemization are all about. These "super groups," if you want to call them that, are a collection of the most viable or some of the most viable institutions in this group. They are living in that same environment, but their survival per se is not threatened. The quality of their products may be, but their survival is not.

Thus I think what this represents is a realization on the part of the leadership of those organizations that by coming together into a group activity of this sort, we can develop advantages for those institutions, we can position ourselves to assist those institutions to be more competitive in an increasingly competitive era, and we can not only take advantage of the opportunities that are out there but also help discover some new opportunities. I think that we have discovered some recently. We are not just adapting. I do not think adaptation is a very noble purpose for doing something like this. Plant life can adapt. I think that it is the challenge of people to help change things in a positive way, and that is what I see in this, not just survival.

It has been predicted, particularly by investment bankers, that by 1990, 65-90 percent of the institutions in this country will be part of some kind of a group. That may seem a little farfetched, but if you take the trend of what has happened through the decade of the 1970s and project it onto the 1990s, you come out at 65 percent. Because of the things that I mentioned--the number of phone calls, the number of people contacting us and, no doubt, AHS, UHS, and others--there is reason to believe that this grouping is occurring at an increasing rate, so perhaps the 80-90 percent level is not too optimistic.

Thus we are in a new context. This new context says that competition is here and, in fact, has been here for some years--we are just beginning to recognize it, and it is beginning to intensify. The new context says that there is now an investor-owned sector in what, throughout our lifetime, we thought of as a predominantly eleemosynary, not-for-profit industry. The new context says that we must shed our fears and our emotionalism about that and accept it and be grateful that they have shaken us out of our complacency and shown us some new models by which we might do better. In this new context we must shed the not-for-profit mentality and accept the fact that there

are opportunities, this is a pluralistic society, and we can continue to prosper and thrive.

As for the kinds of systems we have, there are (1) the investor-owned systems, of which I think Hospital Corporation of America (HCA) is the best example; (2) the not-for-profit systems with a centralized kind of ownership, such as the Sisters of Mercy out of Farmington Hills or Inter-Mountain; and (3) the voluntary systems, such as Voluntary Hospitals of America.

For its first three or so years, VHA began to develop itself as a voluntary organization, with volunteers carrying most of the burden; we employed a lot of consultants and had a very small staff. Then we went through a planning process and decided to make some significant changes to render the organization permanent. Most of us recognized we had been operating in a temporary mode and that if the organization was going to endure in the long haul, it had to do a number of things differently. When we really tried to come to grips with our prospects and goals, we analyzed organizations such as HCA and some of the stronger not-for-profit hospital systems to determine what they are doing or trying to do that gives their individual institutions some advantage. We have identified eight ingredients common to these mature systems.

1. A mature system is one that has reached a level of development and is well enough capitalized and managed that it can endure over the long haul. In those mature systems, the most fundamental element is the development of strong corporate and strong institutional management.

2. These systems also have in common that they either have or are attempting to develop system-wide productivity and quality control programs. With these, they can take advantage of the information that can be generated and controlled within the system to develop indicators for their managers and mechanisms to measure the quality of their product.

3. Next there is the development of human resource programs. Through these the systems take advantage of the scale on which they recruit; recruiting to a system rather than an individual institution is of tremendous advantage. The system can develop career paths and move people where they are most needed. This is a very key advantage of a system.

4. These systems also develop a financial system which enables its units to speak the same language, to mobilize the kind of information that is needed at any point when they need to go to the equity markets or the debt markets, and also to provide operating ratios for the managers of the individual enterprises so they can compare and know what they are comparing as they try to manage the institutions or the component parts of the institutions. The development of system-wide reimbursement

programs, as an example, would also be part of this ingredient.

5. These systems also develop national purchasing agreements, taking the volumes that they represent together into the marketplace and trying to get the best arrangements or the best price for their institutions.

6. Another ingredient is a corporate capital financing plan, which is simply to say, figuring out what you are going to need money for and where you are going to get it, on a system-wide basis. In the vernacular of the voluntaries, that also connotes the efforts they would undertake to improve the capital position of their individual institutions.

7. These systems have insurance programs. So much money is being spent on insurance by these kinds of institutions that you cannot for long ignore the prospects of lower premiums and maybe turning those expenditures into profits.

8. Finally, these systems establish an internal and external image development program. By that I do not mean press agency but a bona fide understanding within the system by the people who are in it about how being part of the system is advantageous to them and to the individual institutions. For the outside, this program presents an accurate reflection to the business community or potential investors so that they understand that system when it does business with them or develops investment or other kinds of advantages.

Those are the elements, either established or being developed, we see in all these multihospital systems. They have done it with varying degrees of success, and that is what we want for our institutions. We think those elements would give institutions advantages if they could be implemented.

You might say, "Well, if that is what you want, and if that is what the investor-owners want, then what is the difference?" I think the difference is one of control and ownership. We prize local autonomy. It is our philosophical point of view that voluntarism has been a very special thing in this society, that the strong qualitative institutions--whether they be health care institutions, galleries, museums, or whatever--have been led by people within those communities with a hands-on attention to the decisions about whom to affiliate with. That is our effort in trying to bring individual advantages to institutions--to preserve that local autonomy.

Let me talk a little more about VHA and our reorganization and how we are going about that.

We are now in 23 states, with about 24,000 beds and probably somewhere between 75,000 and 76,000 employees that are represented in the organization. Our hospitals include Evanston Hospital in the Chicago area, Christ Hospital in Cincinnati,

Tucson Medical Center, Southwest Community Health Services in Albuquerque, Baylor in Dallas, Memorial Hospital Systems in Houston, Ochsner in New Orleans, Baptist in Birmingham, Baptist Hospital, Pensacola, Lakeland General, Tallahassee, Regional Medical Center in Florida, and Baptist in Memphis--a scattering of very good, high-quality institutions that have a great deal in common. They were very carefully selected on the basis of their commonalities as institutions and in the philosophy and the compatibility of the management.

Our overriding purpose is to strengthen and expand voluntarism in health care and to try, through the implantation of these systems ingredients, to bring advantages to the individual institutions by various means.

The VHA is an organizational innovation. It is a for-profit company chartered in the state of Illinois and owned by not-for-profit institutions. It was formed as a for-profit company because it was anticipated that some things would need to be done that a not-for-profit structure could not do. It has chosen to be taxed as a cooperative, but it has entered into, and will do so increasingly, entrepreneurial ventures. The first significant venture is the creation of VHA Management Company, designed not only to create a voluntary presence in that arena but also to make a profit; those profits were to be returned to VHA for distribution either as regular dividends to the shareholders or for use by the corporation to strengthen the systems' advantages.

After some three years of operation and that necessary developmental process with very, very large commitments of time by the CEO and monthly board meetings, we realized that we had probably taken VHA as far as it was going to go as it was organized at the time, so we created a planning committee and went through a year-long strategic planning process. This produced some very significant recommendations, especially with regard to governance. It was thought that we needed a governing structure that could make the organization more flexible, make decisions in a shorter span of time, and move it forward faster.

Thus an executive board was created which presently has seven people; this will expand next January 1 to about ten. The executive board has the power to run the corporation. And we also employ a full-time CEO, not just an executive director or an executive secretary, to run the corporation.

Over the years programs were generally conceived and implemented by representatives on the board. Board members would then agree to serve on committees to develop and implement ideas, usually with the assistance of a consultant. Eventually we decided we had to enhance the full-time staff capability and, to some extent, replace consultants. Committees and consultants can be invaluable in creating and implementing an idea, but they are not very good at running a program.

We had developed some sixteen committees over that first three and a half years. As you know, committees tend to take on a life of their own, and sometimes they are working in concert with organizational goals and sometimes they are not. Committees are hard to control over the long run, and so another key development in our streamlining process was a task force concept in which each task force has a single responsibility, a set time frame, and the necessary resources to address an issue and then move on.

Looking at the long view, we also realized that the governing bodies of the member institutions needed to know more about and to subscribe to this whole concept and to understand why it was important for their institution to be a part of it, so we have begun that educational process.

We have asked each of the shareholders to create a VHA committee at the level of the board of trustees that would function much like the building committee or the personnel committee. It would have a cadre of individuals on that board that would become more knowledgeable about that particular function.

Insofar as growth is concerned, we have had a moratorium on growth almost since the inception of the organization. I think only one new shareholder was taken on board in the first three years, and there was a waiting list of applicants. The planning committee that dealt with that question felt that it would be desirable and necessary to grow if the organization was going to reach its goals.

In order to accommodate that growth and the change in the governing structure, a regionalization recommendation was adopted recently. We have regional offices in Atlanta, San Francisco, and Detroit. Each region will have a vice-president with an assistant whose job will be to interface more frequently with the individual institutions, helping to implement new programs, troubleshoot old programs, and get new shareholders up and running on the VHA programs. We are growing: we have recently taken in a shareholder in Denver, and we have a collection of institutions in the West that we have worked with for over two years; we expect that most of those will be buying shares within the next two or three weeks. We expect to take in additional applicants throughout the rest of this year.

At this point we feel we have a very prestigious group of institutions, and if we can realize our goals, we will be the preeminent system in the country.

I want to return to those eight ingredients so you can see how a voluntary system might address those.

In studying those other mature systems, we noted that it had taken them ten to twelve years to get to the point that they



were, and we have been in this some four years on a mostly voluntary basis. Realistically we are looking at five to six years of hard work before we can consider ourselves a mature system. But as far as our progress on those elements, I think that the management of these institutions would probably have to be measured in the top 2 or 3 percent of management capability in this country. We are just beginning to develop some strength in the corporate management.

In 1982, we have adopted programs in productivity, quality control of human resources, and financial systems, and we are utilizing the services of a management company to implant baseline programs in productivity, human resources, and financial systems within all of the existing, what we call seventy-seven, shareholders (these are the major institutions).

In the human resources area we are beginning to develop career paths for the top managers within each of the institutions, and at the same time we will be inventorying the talent in those particular positions. We will then be in a position to assist our shareholders with the replacement of talent from other VHA institutions. Thus we will be providing career opportunities to the bright people within those institutions beyond what exists within each individual hospital. We will also be addressing the issue of the mobility of skilled people like nurses, to try to make arrangements to keep them within the system if they move from one community to another. These are only some of the human resources advantages to the individual institutions of getting together as a system.

As for financial system, in 1982 we will be installing a baseline program that will be enhanced in subsequent years. We have the beginnings of a system-wide reimbursement program, and that will be enhanced in the future. We probably spent more time on that in the beginning than on any other one thing just because it is the easiest thing to get your teeth into, particularly with what in the beginning was a fairly loose collection of institutions, which has subsequently developed more solidity. It is obvious what a voluntary group of institutions can do; it has been done all over the country since the mid-sixties, and we are getting into the development of that particular area. We are just beginning to collect the information we need from each of the shareholder institutions so that we can appropriately assist them, we are devising programs that will aid their access to capital and the price that they have to pay for money, and we are undergoing an evaluation of what direction we ought to take in the area of insurance.

Also, next fall we will inaugurate an internal image development program to try to develop a greater understanding within each institution as to what VHA is and why the institution is a part of it.

Where do we stand? It is my assessment over all that we are probably at about 35 percent mature status, but I would point out to you that none of those elements in and of itself connotes ownership. Certainly ownership would facilitate the implementation, but we think those things can be done by the individual commitment of institutions, by consensus, and by a lot of hard work. There have already been some significant developments in that regard, and we think that it can be done. In five or six years' time it is our intent to be a mature and viable system. With the kind of corporate and governing functions we have, obviously there are many other things that can be done.

I will just mention one more thing that we think is of value. Earlier discussions here mentioned diversification. We have catalogued the kinds of diversified activities in which institutions in this country are engaged. To what degree an individual institution needs that information will depend on its local circumstances, but we have undertaken to inventory diversifications. We have also determined what our institutions are doing, what their plans are, and what activities they are interested in. The next step is to develop a clearinghouse so that we can match the need with the resource and consequently save an immense amount of time and expense for individual development. The next step beyond that is to establish priorities among those diversified activities. Then we will create VHA products so that when an individual institution has a need for a plan for a surgi-center, a free-standing primary care center, a retirement center, or whatever, we will have predeveloped it in a package which would include floor plans and financial pro formas, staffing patterns, and so forth.

One of the things that we note about coming together like this is the magnetism involved. Everybody out there with a new idea or a new product seeks out groups like this because obviously it is advantageous to them. Some of those are nothing more than just being exposed to marketing or salesmanship, but some are genuine new ideas that may benefit the institutions and the services that they provide, suggesting, perhaps, new services, new ways of doing things, bottom-line savings, access to capital, and other things. That is the kind of thing that will not occur with just an individual, free-standing institution.

Now perhaps you can see that we have taken on much and have accomplished much for a group of voluntary institutions without central ownership. You may not want to bet that we can do it, but I would suggest that you not bet that we can't.

CHAIRMAN FOSTER: Thank you very much. We have time for some questions.

JOHN C. IMHOFF: My question has two parts. One, may your member hospitals retain their own trustee-administrative

organizations without VHA involvement in change, and, two, do you exercise any control over the members of your organization going into multiinstitutional systems of their own?

MR. ARNWINE: The answer to the first is no. We do not intend to interfere with the board structure of those institutions, although we can be very helpful in board education. I think that we can and have already mobilized some programs in that regard which will strengthen the governance of those individual institutions. But as far as how they are organized, we would certainly not interfere with that.

As to whether we would prohibit our institutions from getting involved in their own multiinstitutional arrangements, quite the contrary. We funded the multihospital development program to the tune of a half-million dollars a year for three years to help make our shareholders aware of what is going on in this whole area of outreach, expansion, contracts, leases, acquisitions. The second part of that program was educational, to teach them how to do it if they have the desire to do it. As a third aspect, we have helped them organize to accommodate it once it had been done because we think that is one of the challenges that institutions face today, and increasingly the smaller, particularly rural or outlying institutions, have difficulties and are seeking to affiliate or become a part of some other system. Our institutions need to be sensitive, aware, and involved in that, so we have taken a very proactive stance in that regard.

MICHAEL EBERHARD: It seemed to me that a couple of ingredients of assured systems are really critical to their success: it has been their goal to allocate resources based on the needs of the system, and, second, the single financial state. I realize that both of those are ownership issues. Are you trying to develop any substitute for ownership that might allow you to address those two systems?

MR. ARNWINE: We have talked about that. It is entirely possible from a legal and functional standpoint to pool assets, to pool cash, and to do some of the things that an ownership system can do. It is not realistic in 1982, and whether that will ever be done depends on just how severe the economic pressures become and how successful some of the other programs might be.

JOE CURL: With regard to your purchasing contract, what precedent do you think that will set for your future activities in purchasing, and what precedent might that set for many other large group purchases?

MR. ARNWINE: Let me very quickly review what Joe is referring to. In 1979 VHA signed a contract with American Hospital Supply Corporation that was an innovation which included cost caps that had a 6 percent max per year inflationary factor. It had volume

incentive discounts, and it was based on targeted levels of acquisition from American as a total company. Four local suppliers filed an antitrust action against American Hospital Supply. They did not file an action against VHA or any of its individual institutions.

That was tried in Grand Rapids in April. A decision was rendered by the Federal Court that American was guilty of an attempt to monopolize and conspiracy. Obviously, we disagreed with the verdict. We had the best legal counsel before we entered into the contract, as did American. Nonetheless, that was the decision.

American is appealing it. If the appeal is successful, then the implications of Joe's question would be moot. If it is upheld, then there will be, in effect, a new body of law relating to group purchasing activity.

In the end, as far as what effect it will have on us, the VHA and our institutions will be in the same position as anyone else attempting to do group purchasing, so it is not harmful in that respect.

In essence, what the judge was saying was that, because of its size, American was the only company that could package all of those products and establish cost caps and provide volume incentive discounts on the packaged group of products. He decided that was anticompetitive and that American had entered into a "conspiracy" to help promote that monopoly.

That would not rule out cost caps, at least in my understanding, or volume incentive discounts, but the competition for that business would have to be on an unbundled basis and the products would have to be unbundled. What he is espousing is competitive bidding on a product-by-product basis, and not an aggregation of products that are dissimilar in character. So that would be the implication.

I think it is ironic that VHA's only motive for entering into that agreement was cost containment. By data that we have assembled, we think it is about a \$16 million savings. Nonetheless, the judge felt that he was striking a blow for cost containment.

I do not know what will occur on appeal. We do not want to sit back for eighteen months and wait and see what the appellate court does because during that time we would have our shareholder groups divided into three categories: those in the seven cities that were affected, those in the twenty-three cities that were unaffected, and the new shareholders that would come on board. The way out of that dilemma is for us to write a new contract, which we are doing, that would unbundle the institution and unbundle the products on a divisional basis. The cost caps and the volume incentive discounts would still be

applied, and presumably that would make it more possible for small, local suppliers to compete for that business.

JOHN A. WITT: In addition to the warm feeling your participants get, do they receive any checks annually or anything like that? You were noticeably silent on the payoff and the kind of bottom-line results people in this industry are getting more and more accustomed to looking at.

MR. ARNWINE: We have developed a number of cost-savings programs such as the purchasing program through which the institution gains a cost advantage simply by participating. We have a \$40 million pharmacy program. We think that we are saving, across the board, about 8 percent on the cost of drugs purchased. That savings goes directly to the coffers of the institutions. It simply reduces the cost of running their pharmacies. In the materials management program we think there has been about \$16 million in savings. We have developed contracts for major pieces of equipment, and we have developed patronage pools for some of that kind of activity. This being a cooperative, that kind of business operates not unlike the agricultural cooperative, that is, the more business you do with the co-op, the more you get in patronage income, so that the savings from the purchase of those items go into patronage pools. The distribution of patronage pools last year was about \$5 million.

There is income from entrepreneurial activities, assuming that the management company becomes a profitable venture, and we think it will. We are looking at the development of a reference laboratory, of a leasing company. We have just concluded a joint venture with a couple of other companies which also has the prospects of profitability. Those profits will come back into the organization and will be available at regular dividends.

Regular dividends can be distributed by the shareholders. If they are, they are taxable. We may decide to do that, depending on the circumstance in any particular year, or to simply use that income to defray the cost of implanting these system ingredients.

I do not know how much you believe in productivity, but I happen to think it is probably more of an answer to the cost problem than any of the other things that we are talking about. Thus we think that there will be cost advantages if we can develop a good system-wide productivity program.

So there are economic advantages, although there is more here than just economic advantage, and the economic advantages come in the form of patronage, dividends, regular dividends, or cost savings.

JEFF GOLDSMITH: I would like to ask you to answer Peter Drucker's question: What business is your organization in?

MR. ARNWINE: Our customers are our shareholders, and when they come to the VHA store, I think they are seeking advantage. So in a sense, our product is advantage. What we are trying to do is to give our shareholder institutions an advantage in their own operations, an advantage in their competition with others, an advantage in other ways such as the savings in the development of new programs or new ideas, and an advantage in research that can be done on a conjoint basis.

## FOR-PROFIT HOSPITALS AND MULTIHOSPITAL ACTIVITIES

Joseph C. Hutts

CHAIRMAN RICHARD W. FOSTER: Our third speaker today represents yet another innovative form of multiinstitutional arrangement. The Hospital Corporation of America (HCA) has been so spectacularly successful and well established that you may question whether it qualifies today as an innovative form of organization. However, although the principle of an investor-owned system is well established, HCA continues to be an innovative system in a host of ways.

Our speaker from HCA is Joe Hutts, a 1965 graduate of the program. He held a variety of positions in teaching hospitals prior to his entry into the investor-owned sector, where he has also been involved in a variety of capacities, including contract management. He is presently the president of HCA West, and it is with a great deal of pleasure that we welcome you back to campus, Joe.

JOSEPH C. HUTTS: I want you to know how much I appreciate the opportunity to be here today. The University of Chicago, and particularly its program in health administration, played an important role in my own personal development, and I have always been grateful for the experience that I had here. Even more, I appreciate the opportunity to participate in the annual George Bugbee Symposium. I'm sure that all of us who were exposed to George reacted in our own way, but to me, he demonstrated that kindness and humility were characteristics not of weakness but of great personal strength, and that has helped me tremendously throughout my career.

Before I get started, I would like to make one observation about the last presentation. I think that the VHA is developing a very solid and unique program. It has been my observation that there is a tremendous entrepreneurial spirit in the nonprofit sector of our industry, and I think this kind of approach provides a very unique outlet for it. In my opinion organizations like the VHA have a real potential to make a significant contribution to our industry.

The focus of the symposium is on the emergence of various types of multihospital systems and their influence on hospitals. I will give you some background and insight into HCA and then look at several key areas as candidly as I can and discuss their influence on our hospitals as I see it. Keep in mind that this segment of our industry is young. While free-standing proprietary hospitals have been a part of the hospital business for many years, the real development of investor-owned hospital systems has occurred only during the last fourteen years. By investor owned, of course, I mean private companies which own or manage for others a number of hospitals and are themselves owned by stockholders. Such companies account for over 300 hospitals

or approximately 14 percent of the nation's 5,800 short-term, acute care community hospitals today.

In order to get into specifics, it is going to be necessary for me to focus on my own company. I simply do not know the inner workings of the other investor-owned companies or their operating philosophies. However, HCA does occupy a leadership position in the investor-owned segment of our industry, and so I think it will provide you with some insight into this approach.

My company was founded some fourteen years ago in 1968. The concept actually grew out of a dilemma about what to do with a hospital. One of our founders, a physician, and a group of associates had formed a hospital years earlier in order to provide beds that they felt were needed in their community. They had planned to give the hospital to the city in return for bonds, but the city, as cities sometimes do, decided that it did not want the hospital.

This founder's son was twenty-seven years old at the time and, although a physician, had been interested in business for quite a while. He had been friends with the son of one of the founders of a national hotel group, and he could see the potential of forming a multihospital organization and operating it as a business with a corporate form of management.

A businessman with much health field experience joined with the two physicians, and the three of them put together some \$5 million and formed the company in 1968. All three of them remained active with the company, and their values permeate the company even today.

In 1968 the founders were envisioning a regional company, with maybe eight or ten facilities. However, for many reasons, some of which we will discuss, the company grew far beyond anyone's expectations. Today we are a company that in 1982 will generate \$3.5 billion in revenue and employ between 65,000 and 70,000 people. Our mix of facilities includes twenty-five short-term psychiatric hospitals; over 100 hospitals which are managed for other owners, mostly nonprofit hospitals; approximately twenty hospitals and projects in foreign countries; and some 200 general acute care hospitals we own around the United States.

If I stand back and look at the company over its initial fourteen years, one of the things that I would identify as having a major impact on our hospitals would be our mission statement. Early in our history we attempted to write down what we were all about, and this has influenced significantly the behavior of our people and our hospitals.

We began by saying that it is our mission to attain international leadership in the health care field. This means that very early we were looking for appropriate international



involvement, but more significantly, it dictated the manner in which we would attempt to conduct our business. We feel without question that we have become the leader in the investor-owned segment of our industry. We hope that by the mid-1980s our actions will cause us to be recognized as a leader in the entire hospital industry. In the longer term, we hope to be recognized as a leading U.S. corporation in the generic sense.

Our mission further states that we want to provide excellence in health care, to improve the standards of health care in communities in which we operate, and to provide superior facilities and needed services to enable physicians to best serve the needs of their patients. These mission statements have spawned a very deep-seated belief in our company that if our hospitals concentrate first on providing quality service, such things as a fair return on invested capital usually will take care of themselves.

Finally, our mission says that we will attempt to generate measurable benefits for the company, the medical staff, the employee, the investor, and, most important, the patient. This statement has caused us to focus on measurable results throughout the company.

I review this with you not to expose you to our propaganda, but because, in my opinion, it has very directly influenced the way our hospitals have operated.

Another development that, in my opinion, is beginning to influence our hospitals in a significant way is the continuing strengthening of our board of directors. Don MacNaughton joined our company as chairman a few years ago. Prior to joining HCA, Don had served as chairman and CEO of the Prudential Insurance Company. New people have been added to the board in recent years, and its members now include the chairman of Procter and Gamble, the chairman of Eastern Airlines, the recently retired chairman of AT&T, the president of Wells Fargo Bank, the former president of Aetna, the just retired chairman of DuPont, and the chairman of Rockwell International.

These men are concerned with the viability and direction of our company. Beyond that, they are concerned with what our company is contributing and can contribute to the health care system in the United States and even, to some extent, around the world. For instance, they feel that the cost of health care is the number-one problem in our industry and that as a company we must take a leadership role in addressing this area. This means that our hospitals will have to concentrate on productivity and beyond that become involved in structural changes in the delivery of care. Presently, we have decided on very limited diversification at the corporate level, but we are encouraging our hospitals to consider seriously diversification at the local level, primarily through vertical integration. It is my observation that these men feel that publicly owned corporations

have very real and very heavy social responsibilities, and their view will directly influence the behavior of our hospitals.

Our organizational structure is one that constantly evolves, and for that reason I am always a little hesitant to talk about it. At present we are organized with a corporate staff in our home office that concentrates on strategic planning, capital accumulation and allocation, research and development, and the provision of some overall support services. Our operations are divided into five business units or companies. Our international company owns eight hospitals in Australia; five in Brazil, along with an HMO that serves some 700,000 people; and we are in the process of buying six hospitals in England. We also manage hospitals in Saudi Arabia, Panama, and the Virgin Islands and do consulting work in Egypt, Pakistan, and India.

We have a psychiatric company that owns some twenty-five psychiatric hospitals and is experiencing fairly rapid growth right now.

Our management company manages about 120 hospitals for other owners, most of which are nonprofit. These hospitals include several university teaching facilities, a large number of city/county facilities, church hospitals and voluntary, nonprofit facilities. Our owned general hospitals are organized into an HCA East and an HCA West. Each of these units contains about 100 hospitals.

In a practical sense, I guess the thing that influenced our hospitals more than anything has been our management style. The company made a conscious decision in its early days to implement a decentralized management approach. This approach has been continued over the years and is deeply ingrained in our managers. We try to create a climate in which each administrator feels totally responsible for his hospital and in which he is given the freedom to operate it.

We communicate each year, in writing, the broad strategy under which we want to operate the company. I think I can best give you the flavor of this broad strategy and how it is used by reading part of the introduction to our 1982 strategy statement:

The most important element of the corporate strategy is the creative, analytical thinking of each manager. Most observers expect significant swings in the economy and on the socio-political scene to continue in the 1980s. There will be no such thing as the "standard" that is applicable or appropriate for all areas of geography or operations.

This statement represents a summary of preliminary planning discussions held by the executive officers of the company and each of the principal strategic business units. It outlines overall corporate goals and is intended to be a

general guide and framework so that each manager can develop specific tactical plans and objectives within the boundaries established for the company. It is expected that the tactical plans will emphasize and contribute to those areas outlined as the principal strategic focus.

Nothing in this or any other corporate statement relieves the individual manager of his or her responsibility to think about the future of their area of responsibility. It is expected that the goals presented in this statement and in the planning conferences will be tested for applicability and that appropriate modifications will be made where necessary to provide socially responsible objectives. All executives are expected to be aware of the potential impact current decisions may have on the future and to maintain a high degree of flexibility in meeting the challenges of an uncertain future.

After getting the strategy statement, each administrator then develops a management plan for his hospital. Once he and his immediate supervisor are in agreement on the plan, it is up to the administrator to carry it out. It is understood that as he goes along, he is going to make a number of modifications to the plan. This, in effect, lets us make the key operating decisions, and I am talking about things like wages, prices, staffing patterns, and programs at the hospital level. Our control point is the administrator's immediate supervisor whom we call a division vice-president. We want the administrator to feel as much as possible as if it were his own hospital and he were working for himself. The role of the division vice-president is to stay close to the administrator but not make the decisions. We want him to encourage the administrator when he is heading in the right direction, caution him when he is heading in the wrong one, secure resources for the administrator when requested, and be available to help him think through problems, but not make the decisions. It is vital that the administrators be allowed to make decisions and mistakes. Other companies use other approaches and it works for them, but we feel this approach lets us remain sensitive to the communities we serve and contributes substantially to the development of our administrators, which we feel is probably the most crucial issue facing our company.

We also feel that our multihospital structure provides us with an unusual capability to develop our managers. Our administrators usually begin as assistants, unless they come to us through an acquisition, and then each begins functioning as the administrator in a fairly small hospital. As he develops, he progresses into larger and larger hospitals, and if, somewhere along the line, he runs into trouble because of politics (and there seems to be a lot of that in our industry), he is not automatically out of a job but, rather, is given a new hospital. Certainly, progressing from one size hospital to

another is not new in our industry, but it is done with the same employer, within the same corporate framework, and most important, with the intention to develop the manager.

We have also found that lateral moves can enhance development, particularly when they are into roles that broaden the person, such as international, research, or marketing. I think the major avenue we have provided for personal development is the opportunity for administrators to move into multihospital responsibility and then even into corporate-type roles. This kind of career growth simply was not available when I entered the field. In my opinion, this is a very positive development for our industry.

I have been talking about areas in which we have influenced our hospitals, and I want to mention a few more. First let me mention an area in which we have not had much of an influence on our hospitals, and, interestingly enough, this is a reason often given for forming multihospital organizations. I am talking about referrals. Very honestly, we have not made a major impact on the referral of patients from one hospital to another. As we grow and mature, we can see the seeds of referral relationships building, but so far referral practices among our hospitals have developed spontaneously, and we do not feel we have caused an increase in referrals.

One thing that has affected our hospitals significantly is the availability of capital. Many of the hospitals we acquire are in need of major capital expenditures, and we have been able to meet these needs. For instance, over the past few years, an important part of our construction has been the replacement of hospitals formerly owned by city or county governments. These hospitals are typically ones constructed twenty-five or thirty years ago. City and county commissioners are faced with a very difficult problem in that capital is needed for many public facilities such as schools, public utilities, and the like. We have acquired fourteen of these hospitals in the past two years for the purpose of replacement and major expansion.

While the majority of capital raised by the not-for-profit organizations is through tax-exempt bonds, we have had multiple sources of access to capital through a variety of equity, commercial paper, and debt instruments.

For instance, during the last year, HCA raised over \$1 billion of capital through (1) equity capital through issuing new stock, (2) U.S. bank loans, (3) U.S. convertible debentures (these are debt instruments that convert to equity when a certain stock price is reached), (4) U.S. privately placed debentures, (5) Eurodollar convertible debentures, (6) Asian bonds, (7) industrial revenue bonds, (8) commercial paper, and (9) foreign banks.

There is very clearly increasing competition for the capital dollar. Let me point out, however, that companies such as mine compete largely in a different market from that of not-for-profit hospitals. We are competing in the debt markets with the other Fortune 500 companies and have attempted to make ourself known in all types of capital markets around the world. Today, we borrow from twenty-five foreign banks, for example.

As one of its financial policies, HCA has the maintenance of a 60:40 debt-to-equity ratio and a return on capital of a minimum of 10 percent. If successful, this formula will allow us to generate internally the majority of our equity needs. Fortunately for us, the equity markets have been available to us in the past two years and have allowed us to maintain our debt at approximately 60 percent of capital while purchasing three publicly held hospital companies and continuing an aggressive construction and single-hospital acquisition program.

It seems to me that the availability of capital probably will become a major issue not only in our industry but around the world. We are trying hard to position ourselves to take advantage of capital sources wherever they are, and I think this will have a continuing influence on our hospitals.

I have been asked to comment on our influence on physicians. Because two of our founders were physicians, I suppose we have focused on them more than some organizations. We understood that the physician has traditionally determined who would be admitted. We also realized that he controlled many of the internal forces in a hospital and was the major determinant in cost and quality. We felt it was vital to involve him in the key decisions.

At every hospital we own, we form a board of trustees that gets involved in virtually every policy issue facing the hospital. This board usually consists of half community representatives to help us stay sensitive to the community and half physician representatives, and the administrator also serves as a member of the board.

I know that our industry has debated for years about physician involvement on boards of trustees, but we have found that if they are actively involved, if they are given information and a voice, they can contribute substantially to the hospital.

Although some companies have chosen to involve physicians financially, we have not. They can buy HCA stock as you and I can, but, frankly, we have felt that giving them involvement was more important and effective than a financial interest.

Right now we feel that we need to be concentrating on our relationship with physicians. As the supply of physicians increases and produces a surplus in some specialties, in some

localities, their real income may erode. This may well cause them to become more competitive with the hospital. We are thinking hard about our relationship. I mentioned earlier that we feel it is important to address the cost of health care. We feel that this cannot be done effectively without their deep involvement. In our opinion, it is crucial for us to find the means to be able to pull in the same direction.

Another characteristic of multihospital systems is the development and sharing of support resources. I do not know if our resources are unique, and certainly many systems have specific programs in various areas that are more effective than ours. However, we do have a very comprehensive base of resources that are available to our administrators.

I will not review all of our resources, but consider a few that I think are especially important: (1) a design and construction team that has built some seventy-five hospitals and expanded numerous others; (2) a finance staff that continually raises the capital needed in our hospitals; (3) a physician-recruiting organization that helps find physicians needed by our hospitals; (4) a human resources organization that provides ongoing labor relations assistance and, perhaps more important, continually aids in the recruitment of new administrative talent; (5) a data processing system that lets us deliver basic data processing services and enables us to have comparative data, which we think is very important; (6) a legal staff that handles health law questions; (7) a materials management function that lets us secure major discounts through several hundred national and regional agreements and provides equipment planning and specification for new hospitals and expansions; (8) a management services function that tries to pull together all the knowledge we can about the operation of a hospital and puts it together in various systems and programs; currently we make available systems to our administrators, including unit dose systems, productivity systems, inventory control systems, nursing management programs, cardiac rehab programs, census building programs, and business office systems; (9) a large reimbursement organization to make sure our hospitals receive the maximum reimbursement allowed; (10) a wholly owned insurance company to provide malpractice insurance to our hospitals as well as risk-management programs and monitoring; and (11) an educational center that provides ongoing educational programs for supervisory personnel in the hospitals as well as development modules for administrators and other key managers.

Our administrators make the decision about when and if they will use these resources. So far, many of our resources have been directed toward the strengthening of new hospitals we build, buy, or contract with; but over time, I think these resources will make significant contributions to our hospitals and will influence them directly.

Another influence we have had on our hospitals, and I'd like to believe on many other hospitals, is an understanding that they must generate a reasonable profit. Many people in our industry have been confused about profit. It seems to me that Peter Drucker says it well, and I quote:

To most businessmen, as to most economists, the need for profit is obvious. There is therefore among businessmen and economists a growing awareness of the inadequacy of the rate at which businesses today earn the costs of staying in business. But for the public, the politicians, the trade union leaders, and even for the senior people in organizations--let alone employees on all levels--this obvious fact is totally invisible. It is obscured by the prevailing rhetoric of "profit." "Profit," we are told, is a "reward" to the investor. Nothing could be further from the truth. What is misleadingly labeled "profit" is genuine cost, the cost of the future of enterprise and economy. A rate of profit that does not equal the cost of capital is not "profit" at all. It is loss, both for the firm and for the economy.

A deficit is a deficit, whether incurred by a soap maker, a university, a hospital, or the Boy Scouts. Managerially and entrepreneurially, these are very different institutions: Economically, the only difference between them is the way the tax collector treats them.

At the same time, I hope we have demonstrated we only need to earn reasonable profits. HCA makes a profit margin of about 5 percent, about the same as well-run individual hospitals. I would like to think that we are helping in this area because it is vital to the long-term well-being of our entire industry. The fact that our company distributes a portion of its earnings to owners should be considered a plus. For example, 65 percent of HCA's stock is owned by large institutional investors who have demonstrated a willingness to finance HCA hospitals for a reasonable return. Fifteen percent of our earnings are paid out as dividends, and the remainder is reinvested in the enterprise.

In 1980, HCA paid a cash dividend of twenty-seven cents a share. At the end of the year, the stock was selling for \$37 per share. That is an efficient and relatively cheap cost of capital. A hospital borrowing \$37 with tax-exempt bonds would have paid in 1980 between \$3 and \$4 for interest expense alone.

For this very reason, it would not surprise me to see some nonprofit hospital groups adopt the investor-owned model of ownership.

I might also say in passing that, because we are organized as a for-profit company, we receive a return on equity through the

Medicare program. During the last five years HCA has received \$94 million that would not have been received if we would have been nonprofit. However, during the same period we also paid some \$93 million dollars in local, state, and federal taxes. A pretty equal offset.

Another area in which we are trying hard to influence our hospitals is the area of pricing. A while ago I mentioned the broad strategy guidelines we provide to our hospitals. In recent years, we have told our hospitals that as a company we believe it is very important for our charges to be well in line with other hospitals. It is important to meet our earnings goals, but it is every bit as important to contain the cost of health care. Our data show that we are doing that.

In Florida, we own some thirty hospitals. The Florida hospital cost-containment report for 1980-81 shows our charges on a per case basis running well below their peer groups. In Utah, we own six hospitals. The report of the Utah cost-management foundation shows our hospitals running below our peer groups; and in Texas, where we own some fifty hospitals, the 1981 Blue Cross data show us running slightly under our peer groups and well below state averages. However, it shows the recently acquired Hospital Affiliates hospitals running well above their peer groups. This means that over the next year or two, we will have to restrain prices in order to bring them in line.

I realize those comparisons do not reflect case mix and other factors, and I do not mean to imply, by any stretch of the imagination, that HCA is performing better than other hospitals. However, we are satisfied that, on the average, our charges are well in line with those of comparable facilities, and that fact is important to us.

The important point to me is that we have been able to influence the pricing policies of our hospitals and still meet our financial objectives.

Finally, HCA is rapidly moving into a situation where it can influence many hospitals throughout the country, even those outside our own organization. Never before in the hospital industry has there been an organization with the size and the visibility of an HCA. Increasingly, our thoughts, our stands, and, most important, our actions will influence many hospitals. We are committed to being a positive force and using our position to strengthen our industry.

Thank you for giving me an opportunity to review our experience with you. I will be happy to answer any questions you might have.

CHAIRMAN FOSTER: You talked a bit about influencing physicians, but you did not say much about influencing



physicians' clinical decisions, such as, for example, the laboratory tests that Donna Regenstreif talked about earlier. Would you address that issue?

MR. HUTTS: That is what I mean by influencing them, and we have to be finding ways to do that. We are trying to find the incentives to encourage them to act in ways that are consistent with what we think has to be done, and if I knew what those incentives were, I would tell you. I don't know.

MEMBER: I am interested in where you see HCA going within the next ten years, and are you giving any thought or any planning to moving into tertiary services with any of your consultants?

MR. HUTTS: Basically we are going to stick to the business we know best for the foreseeable future. I do not look for any diversification out of hospitals through the mid-eighties except that we are going to concentrate very hard on vertical integration at the local level, but we want the administrator to make that decision based on local needs and not on some lofty thoughts that somebody in Dallas or Nashville or somewhere else has. By the end of the 1980s I would expect us to diversify into some other area of the health field. But we are committed to staying in the health field.

As far as tertiary care is concerned, we do manage a few university teaching hospitals. The kind of hospital that basically has been for sale has been the community hospital, and that is what we are made up of, and it really would not be appropriate for them to be involved in educational programs.

We have tried recently to buy a hospital with a significant educational program, Prince George's County Hospital in Maryland. We had an agreement worked out which was killed at the last minute because people thought because we are a profit-making company we might not be able to act in the public good. But we wanted to buy that, and I think increasingly you will see us get involved in tertiary care and teaching programs. We do not have a corporate stance one way or the other. If the right opportunity presents itself, we will take advantage of it.

PETER WEIL: I am curious about your career path methods. When you recruit, do you recruit from graduate programs or from other hospitals? One of our previous speakers suggested, I think, that you go for functional specialists. Would you care to comment on that?

MR. HUTTS: We are a little different in this respect than other companies. Almost all of the administrators we hire are M.H.A.s, or M.B.A.s like Chicago with concentration in hospital administration. Although we hire very few fresh out of school, we like to take a person with two to five years' experience and put him in as an assistant for a relatively short period of time, maybe six months to a year, and then he will move out as

an administrator.

As far as who runs our company, I would say the most significant operating influence in our company at all levels is the person trained in hospital administration. We do have some division vice-presidents that have come up the financial route, and the fellow running our psychiatric company is a psychologist. However, if you look at our senior management, except in the functional areas like law and finance, if you take the operating areas, the five strategic business units, the majority of them would be people trained in hospital administration. I believe hospital administrators can make good corporate executives.

GARY A. MECKLENBURG: Would you comment on the general effects on corporate strategy of the environment of the state in terms of such things as rate regulation? Obviously, when you look at your physical locations around the country, there are some states that are more attractive than others.

MR. HUTTS: We have basically decided not to put equity capital in states that are very heavily controlled by regulation. However, we are trying to position ourselves to take advantage of the future. For instance, we have opened an office in Boston; we probably manage fifteen hospitals now in the Northeast. We think that maybe some day somebody is going to wake up and realize that you have to let a hospital survive. You have to allow a hospital a profit margin at least equal to the cost of capital. We do not need a tremendous profit margin; we need what any other hospital needs. When people come to recognize this, we want to be there and be known and have demonstrated a track record, so you will see us entering the Northeast and other regulated areas, but not in the form of equity.

We have found out that not all states in the Northeast are heavily regulated. For instance, we were in New Hampshire, in a management contract. It turns out to be a pretty good state to operate in, so we may make an equity involvement there.

DONALD J. CASELEY: I am interested in a comparison of the profitability of your international division and your domestic operation.

MR. HUTTS: The international division has an objective to contribute 10 percent of our pretax earnings. It doesn't; I think this year it is contributing about 7 percent. Management contracts would contribute about 2 percent and owned operations would contribute the bulk, the vast majority.

I might add that we are involved internationally because we feel that with regulation and so forth in this country, there may be a time when having an equity involvement internationally could offset a problem here in some area. We feel that

management contracts internationally are volatile, and we are investing equity in selected locations, but that too can be a risky business. I can tell you we are learning more about inflation than we are about HMOs in Brazil. But there are tremendous needs internationally, and even though there are risks, we will continue to expand.

DONALD CORDES: You mentioned you had what you call a census-building program. The reputation of many of the investor-owned organizations is that they will do all they can to maximize utilization. Would you comment on this issue?

MR. HUTTS: I like a good census, as you do. When we talk about a census-building program, we are essentially talking about a good long-range plan. It involves our looking at the community to see if there are any services that are not provided that we can provide, such as psychiatric beds, dialysis, emergency rooms. We talk to the physicians to try to find out what they like about us and what they do not like. We talk to the community representatives. Basically it is just like any other company. If there is room for a service that is really needed in that community and is not being provided, and we think we have the capability to do it, we will do it.

I can certainly pick up a bit of the implication of what you are saying, and I think it is important to keep this in mind. I do not mean this to sound self-serving, but people like myself are not going to be a part of something that is not solid, just as you wouldn't.

STEWART BURSTEIN: I would be interested in any thoughts you have about reconciling the differing objectives of HMOs and hospitals.

MR. HUTTS: Well, I don't know that as organizations their objectives really differ. Perhaps you are implying that hospitals need to have patients and HMOs need to not have them. I would get more basic than that, and I would say that all organizations have a purpose of surviving and staying healthy, in addition to the purpose in our case of taking care of patients and rendering quality care at a reasonable cost, so I do not really see an incompatibility. I think the HMO model or parts of it may be one that a lot of us end up with, if it works.

The health field will probably have some major restructuring in the foreseeable future, and most of us are going to be involved in those things that effectively contain health costs. I think we have to say that the number-one key issue right now is the economics of it.

GEORGE BUGBEE: How much are you improving efficiency through functional advice from, for example, nursing and dietary staff, and do you do any sort of on-sight visiting to see what is going

on? What do you do that is better than the individual hospital can do, other than those things you have mentioned?

MR. HUTTS: I worry a lot about that, and a lot of times I am convinced that we do not do anything more or at least not nearly enough.

We have tried very hard to look at each functional area of the hospital to pull together all the knowledge we can. Take the area of nurse staffing. What does anybody know about nurse staffing that would help our hospitals? Most of the good ideas we get come from the nonprofit sector; some of them come from our own research, some of them from other businesses. But we will take everything we can that might help in the nursing situation and, for instance, put it together in some kind of a program or system that can be implemented fairly easy. We then have people on our staff that will help implement that system in the hospital.

Whether or not we are making a difference will be the test in the long run. We are growing so fast. We buy so many hospitals that require a lot of specialized resources it is hard to get a handle on it, to be honest with you. Based on my observations as a hospital administrator who has worked in many different hospitals, I think that over time we will make a significant contribution.

BEAUREGARD STUBBLEFIELD: As far as the board of trustees in individual hospitals, I am curious about how you see their role and how you go about selecting them. I know you mentioned that you have community representatives, and to have physicians is fairly unusual there, but also, what do you look for in community representatives in your local hospital?

MR. HUTTS: On the community side basically we look for community leaders, and we will turn to them. If it is a city-county hospital that we buy, we will usually turn to the leaders in the city government for ideas. It is not hard to spot the leading citizens, and we are basically trying to get those people who will have the interest of the community at heart because in the long term, if we do not meet the needs of the community we serve, we will not be in business. So we want people to say, "Hey, you have a responsibility here," and it keeps our feet to the fire, and we think that is good.

The physician members are selected mainly on recommendations from the administrators, who believe that certain physicians can think in a big picture and can contribute. Physician board members change every so often so that new people can come on.

The administrator serves as a member of the board, too, and I think that is important, and he is the only HCA representative on the board. We do not have division vice-presidents or anybody else at the board meeting. The administrator represents

the company.

GEORGE BELSEY: What authority does the board have?

MR. HUTTS: In a practical sense, tremendous. I cannot remember, except for one or two instances, ever going against the board. We want it involved in every policy issue, and for all practical purposes, if the board members make a decision, in the vast majority of cases it will be implemented. This is primarily because we believe that, if ten of us sat down and looked at the same information, and we had an opportunity to discuss it, chances are that we would each arrive at the same conclusion. The process of decision making is often more important than who has the right to make the decision.

HARVEY DERSHIN: You referred twice to having a commitment to structural change in the field. Would you elaborate on that?

MR. HUTTS: It is not that I have a commitment; I just see it coming. I think that we must do something about the cost of health care. I would like to believe that creating an investor-owned hospital company would bring enough economics that that would be the only answer, but it is not. The only way that we will be able to make a real impact on the cost of health care is through some structural changes. We must develop incentives for the people who buy health care to act differently. We must develop incentives for physicians. We must develop incentives for ourselves. Those things will cause the health field to be restructured to some extent. I wish I knew which way. I would get out there and capture all that revenue.

JEFF GOLDSMITH: I would be curious to know, in the regional reorganization, what functions have been lodged in Dallas and what functions remain in Nashville?

MR. HUTTS: We are in the process of evolution. The statement on the front end was that everything that supports our hospitals on a day-to-day basis, we are going to move out there. We took a first cut because I only wanted so much at first. In Dallas we put things like all of our systems, our functional specialists, physician recruiters, our industry engineers, reimbursement, materials management to help us do regional contracts, finance, and human resources--eventually everything except those things that are used every once in a while, like construction management. I would think that that would probably always be something we will leave centralized. Capital accumulation, education, and research are also centralized.

The trick for us, and I think for any multihospital organization, is to control our overhead, and I have taken the position I do not want a function to appear in Dallas unless it disappears in Nashville, and that slowed things down a little bit.

CHAIRMAN FOSTER: I would like to ask you a little bit more about the vertical integration. First, given your emphasis on decentralized management, what do you do to encourage vertical integration at the local level, and second, what kinds of corporate support do you provide? Anything analogous to the programs you mentioned with regard to nursing staffing?

MR. HUTTS: We are just beginning to think about this. We have a task force convened right now on alternative delivery systems with a lot of subgroups. It will function for a year, and we are addressing vertical integration. In a recent strategic planning session we argued about the incentives that must be provided to an administrator or division vice-president to act as a catalyst to bring about vertical integration. We are not in agreement on this: some people think that the administrator has enough self-motivation, other people think not. I do not know the incentives.

I might mention that as a company we do not have a bonus program. We have a stock option program, which has been attractive. But we have not gone to other kinds of financial incentives. We may, and certainly we are considering that, and I would argue that there is pretty good evidence in many companies that financial incentives cause people to act in a certain way.

CHAIRMAN FOSTER: You mentioned also that just being an investor-owned hospital was not enough, that solving our problems would require structural change. So I wonder, apart from your association's lobbying in Washington to encourage competitive reform, what are you doing to try to bring about structural change?

MR. HUTTS: We are trying to identify first of all those things that can really address the key issues, like the cost of health care. When we have that sufficiently thought through, we will see if we can make it happen, but we will do so based on the local hospital administrator and not figure that we have some great knowledge or that everybody ought to do the same thing. That is not true. Perhaps one administrator ought to start a nursing home, another ought to become involved with an HMO, another ought to put in primary care centers. That is something that we think should be determined at the local level.

## A VERTICAL-HORIZONTAL MULTIHOSPITAL CASE

Carl N. Platou

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The third and final session of the Twenty-fourth Annual George Bugbee Symposium on Hospital Affairs convened at 9:00 A.M. with Dr. Reed L. Morton presiding.

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CHAIRMAN REED L. MORTON: In keeping with the theme of "Multihospital Systems and the Individual Hospital," today we have two speakers with extensive experience in what some look on as a phenomenon and others would call a historical fact, namely, the development of multiinstitutional systems. The first speaker is Carl Platou, president of the Fairview Community Hospitals. He is a graduate of the University of Minnesota Hospital Health Services Administration Program.

CARL N. PLATOU: Thank you very much; it is a distinct honor to have an opportunity to visit you and the seat of health care administration in the United States. I would like to begin with one basic point, that is, the Judeo-Christian ethic of health care in the United States and how the formation of our organizations called hospitals derives from a motivation of caring for others. This is reflected in the Sisters' hospitals, the Methodist hospitals, the Sinai hospitals, the Presbyterian, Episcopalian, Mormon, Seventh Day Adventists, Lutheran hospitals--all of the 7,000 nonprofit hospitals in the United States. Our origins, other than community development, are the Judeo-Christian philosophy and the teaching of concern for others. Now we are finding in the United States a new discipline, a new criteria for health care, that is, returning money to an investor, a person who is an indifferent party but nevertheless a key player.

About ten or fifteen years ago there was a seminar at Duke University which considered the subject of multihospital systems and concluded that they had no future. What has happened since then to make them a (growing) reality?

With demographic changes in the U.S. population came a tremendous and widespread need for new facilities and programs. Because of its organizational structure, the nonprofit system was unable to respond. The greatest factor, I think, in the inability of those hospitals to respond to community need has been trustees. "Trustee" means to hold in trust; it implies, therefore, an inability to take risks. "Director," however, implies assumption of risk for investment return.

Perhaps trustees are not the only people disinclined to take risks. Those of us who have been graduates of hospital administration programs learned how to work with and understand

the trustees, medical staffs, community needs. We have been educated to understand problems and to be concerned about them, but we are not necessarily educated to take risks and to be leaders.

Thus those of us educated in hospital administration and our trustees did not find it possible or proper or timely or prudent to expand, to discuss invading or developing new markets. That was contrary to our whole philosophy of health care. We believed that we must satisfy the patients and the physicians in a given hospital with its medical staff and its committees; we learned to attend to the educational programs, the standards of care, the quality of care in that given hospital. That was our responsibility.

Fairview was a 165-bed hospital in downtown Minneapolis when I started, and then, with the good grace of people in the Twin Cities, we started a second hospital called Fairview Southdale. We then asked, What next? It became abundantly clear that there was nothing next because there was no organizational framework in which to do anything. In those days the investor-owners were considered scalawags, so we certainly did not want to be proprietary. We sought a frame of reference that would be understood by bankers, because they always control nonprofit boards, and that would be understood by the community and would have comparability--comparability with local boards of prestigious people, comparability with the flow of resources, flow of influence, flow of management from one to another.

So twelve years ago we established the concept of a hospital holding company, somewhat on the model of the bank holding company, and wrote about it in Harvard Business Review. Out of that simple concept, out of that very simple idea, began to emerge a point of view, an orientation within a board to look on health care as a regional concern, not just that of a given address for a specific institution. This tended to bring about a change in the philosophy of management.

While we were starting this, lo and behold, the investor-owners began their phenomenal growth.

In the nonprofit field we have been, in many different ways, attempting to have a broader response of greater velocity and greater variety to the conditions that face us--organizational stress, financial stress. We have been trying to understand what the needs of the future might be and how we can meet them. Organizations like Voluntary Hospitals of America are a marvelous reflection of the vitality of the nonprofit system. In fact, I would like to entitle my talk "The Fall and the Decline of the Investor-owned Health System in the United States of America, July 1, 1989," just for fun, to get some discussion going. The investor-owned organizations have no commitment to health care. Their commitment is to the investor. However, the investor-owners are the organizations that taught the nonprofit



field that it had to do something different.

The real question I raise with you this morning is the matter of society's enduring values in the area of health care. The question is whether you and I and the rest of us in our boards have the ambition, the skill, and the willingness to modify our present and understand the future and to modify our organizations so that we can compete effectively against the investor-owneds, because if we do not, the investor-owneds will take over. And they should because they are outperforming the nonprofits.

A vacuum has been created by the nonprofit boards and the administrators who have sat with a sense of complacency and self-justification because of their good works. But that is not all the public needs; it needs response.

Ours is a small organization of Norwegian-Lutherans in Minnesota. It is now in twelve states with fifty-eight hospitals, which are not in superficial relationships of sharing services and the distribution of sponges and notepaper but are managed on five-year profit contracts. The investor-owneds taught us a lot.

In the health care field you must ask yourself, What are you doing it for? What are you going to get out of it? What is the bonus arrangement? What is the stock arrangement? In a recent issue of Forbes magazine the chairman of Whittaker, a corporation originally concerned with oil exploration, talked about its involvement as an investor-owned hospital system. Today a large part of Whittaker's portfolio and earnings come from the health care field. The chairman made an interesting point which tells the whole basic story. It is not for me to say that the investor-owneds will decline, but note what the chairman of the board of Whittaker said: "The moment that our earnings curve and dividend return slumps and we lose that thrust within the market, we will be going back to drill bits in the oil field." And so they should, because their commitment is to return money to the investor. It has nothing to do with a commitment to health care. The mode of operation, not the commitment, is in health.

I draw that line of difference, not to say that the investor-owned organizations are improper in what they are doing, but to sharpen the discussion of what is happening in the U.S. health system and will continue to happen unless the nonprofits with their boards and their managements determine that they operate in something other than the traditional way to render health care.

Philosophically we are committed to growth and expansion, and we think it will occur because you can really prove in competition with investors and other nonprofit groups a better performance for a given community hospital. We compete in our

community with Health Central. They are a marvelous group of people, very agile, very ambitious. They are the best thing that ever happened to us because we compete: it causes a sharpening, it causes you to focus on your efforts.

Perhaps a historical analogy would clarify my meaning. After World War I, the French were convinced that they had defeated Germany forever. In fact, they were so convinced that Germany would never rise again that, after they constructed the Maginot Line with its artillery pointed toward Germany, the French decreased the size of their armies and let their air force disintegrate. Many of you know what happened. The Germans did something different. Instead of being oriented to trench warfare, for which the Maginot Line was constructed and suited, the Germans created a number of things, among them, the Luftwaffe, the panzer divisions, and the paratroopers. With these the Germans went around the Maginot Line, and France capitulated in a few weeks.

The investor-owners acquired capital, sold stock, made a huge return. Why? Because they could pick up nonprofit hospitals that were weak. They could move into areas where there was tremendous growth because the nonprofit hospital boards sat on their hands and did not move, did not compete, did not think it was their mission to do so. The nonprofits were utterly overwhelmed, like the French.

The game has changed. The Maginot Line is no longer adequate. A fine reputation for the hospital and its medical staff is no longer adequate. So what happens? The investor-owners flourish.

I am not against what the investor-owners are doing. It is laudable. It has brought the fundamental issues in the delivery of health care in the United States to a sharper focus. Today there are opportunities for nonprofit boards of trustees and administrations to take advantage of in their own way, in their own communities. The opportunity to compete and prevail is very strong and is good for the health care system.

## A HORIZONTAL MULTIHOSPITAL CASE

John King

CHAIRMAN MORTON: John King attended the University of Minnesota Graduate Program in Hospital Administration. He was the first president of the Holy Cross Health Care System in South Bend and, following that tenure, assumed the post of executive vice-president at the Evangelical Hospital Association (EHA) here in the Chicago area. He has been serving in that capacity for approximately two years.

JOHN KING: I want to share with you some of the things that are happening at EHA and give you some insight into our organization and its activities.

We are located in Chicago and serve the greater Chicago area. We have five hospitals in this metropolitan area, and we operate about 1,600 beds along with a school of nursing, two elderly residential housing programs, a holistic health care center, and about three other ambulatory care centers. Our gross revenues are about \$273 million a year, and we expect to make a profit of about \$9.7 million this year.

As an organization, we are nonprofit, church related, and we are both inner city and suburban. The organization, I think, is one that has been characterized as risk taking. It is somewhat tenacious. It has a high level of centralized services for its hospitals, and it has great diversity among its five institutions. For the future, it is oriented toward growth and diversification.

EHA was founded in 1906 by a group of German immigrant ministers from the Evangelical Church. Thus the history of the organization and its heritage is characteristic of many hospitals in this country in that it was founded as an extension of the ministry of the church to provide a place for the care of the sick, especially of that particular denomination.

Evangelical's hospital was located at Fifty-fourth and Morgan and existed there until the early 1960s. Our corporate office is located in Oak Brook, and the "flagship" hospital of this system, Christ Hospital, is located in Oak Lawn, a southern suburb. This hospital was originally built in 1961 as a 200-bed institution. Today it is an 860-bed institution serving the greater southern suburban area of the Chicago metro area. It is a major teaching affiliate of the Rush Medical College, with about 150 residents and undergraduate students.

A few years after Christ opened, the hospital at Fifty-fourth and Morgan was turned over to a group called Tabernacle who operated it for a few years and then closed it, so for a short

period of time in the early 1960s, EHA was operating two hospitals. The black community criticized EHA for allegedly turning the hospital over to an organization that was destined to fail. I think it was out of that experience that the people of the EHA dedicated themselves to returning to the city of Chicago at some point in time to provide health care services.

The School of Nursing is operated as an independent organization under our corporate organization. It happens to be on the same campus as Christ Hospital. It has its own governing body and reports to our corporate administration, not to the hospital with which it shares its campus.

Good Samaritan Hospital, which opened about five and a half years ago, is a 276-bed hospital in Downer's Grove. It is a general acute hospital serving the western suburban area.

Two and a half years ago a hospital was opened in the northwestern suburb called Barrington, a community that is known for its affluence. However, it also has a small number of very poor Latino people. This institution has 166 beds.

About the time this hospital was under construction, EHA became involved with a management contract with a hospital on the west side near Garfield Park. This is an area of Chicago that during the sixties was probably one of the most devastated by the riots. This 150-bed hospital was turned over to EHA for management three years ago; two years ago it became a controlled subsidiary, and two months ago it merged with our parent corporation.

Woodlawn Hospital, located about two blocks from here, is a small, 150-bed facility that has served as a community hospital for the Hyde Park area for about fifty years. It also merged with EHA about three years ago.

A year ago in Downer's Grove EHA opened two elderly residential housing facilities. Both of them have about 150 apartments. They have atrium-type design, somewhat on the Hyatt concept. When the 300 apartments were put on the market, we received applications from about 3,000 individuals. (So if you have any concern or interest as to whether there is a market for elderly housing in Chicago, I think there is.) These two facilities have been very successful. A third elderly housing project will be under way some time this summer and will continue to pursue opportunities in the elderly housing area.

Our holistic health care center was started with some help from the Kellogg Foundation in Holistic Health Care Center's, Inc., here in Chicago. It operates in a church near Christ Hospital and provides an opportunity for outpatient care with a team of people, including a nurse, a physician, a minister, and a counselor. This is an opportunity for us to provide a delivery system for people who are seeking a holistic care

program.

One of the things that you can surmise from this brief introduction to EHA is that it has really grown from almost a single hospital operation to a fairly large and complex system within a short period of time, the last five years. The opportunities in the Chicago area were such that Paul Umbeck and the board were able to take advantage of them, but at the same time that has posed fairly interesting challenges to this organization in terms of developing a management structure and a governance structure that would accommodate that kind of growth.

Let me talk just briefly about how EHA is organized. We operate almost all of our activities in a single corporation. In our field now there is much interest and activity in legal restructuring. At the present time our organization feels that most of its activities can be conducted within a single corporate entity. We are studying reorganization and will probably make some adaptations. However, for an organization like ours that has 98 percent of its revenues coming from acute care, the pressures for reorganization are not great. They will be in the future due to diversification plans.

Our organization has a rich heritage with its church, and I think that as I describe the governance function, you will begin to understand a little better that our church relationship is not one in name only. We have an association with about eighty congregations in the Chicago area that provide the corporate membership of our organization, and that membership elects our board of directors. Six members of our board of directors are clergy from those eighty churches, and all of our board members come from the membership of these churches.

We communicate with those churches, use those churches as our constituency, raise money through those churches, and, as a church-related organization, we conduct EHA's activities as a ministry and an extension of those congregations. So the thrust and much of the decision making in our organization is based on this: We really view the activity of this organization as a ministry of the United Church of Christ, and with that come some obligations and some opportunities. I think it does provide for us some of the value system that, as Carl was describing, may be lacking in other kinds of health care organizations. I would add that value problems are not confined to the for-profit sector. There are, unfortunately, a lot of nonprofit hospitals which do not have their value systems very clear either. We are working at our philosophy. We think it is an asset to us and part of the strength of our organization.

The governance of our organization has undergone much change in the last five years. Currently we have a governing board of nineteen members, and they are responsible for the operation of this organization. They are primarily involved in finance, planning, resource allocation, and policy development. For the

last two and a half years there have been governing councils at each institution, so we have a split governance relationship. We have a governing council at the school of nursing as well.

Each governing council usually comprises nine to fifteen members, including two physicians, the administrator, two board members from EHA, and four or more people from the community. That mix of governance at the hospital enables us to have input from the community; at the same time it provides a certain amount of stability from the corporate standpoint, and it also includes the important physician and management constituency. The role of the governing council is to develop hospital policy under the umbrella of corporate policy, to develop public relations and development programs for that hospital, to provide community input to the operation of that hospital and to the planning for the future of that institution, and to provide a governance function for review and oversight of management at the local hospital.

The authority of the governing councils consists of the appointment of the medical staffs and medical staff relationships and the development of hospital policy. In the financial area, they approve all capital expenditures between \$25,000 and \$50,000 and all unbudgeted expenditures under \$10,000. Budgeted capital expenditures above \$50,000 are approved by corporate management. The local governing council has a very key role in the planning process at that local hospital, so the governing councils are not just advisory committees. They are given specific decision-making responsibilities, and they provide a very vital local community role in the governance and planning of the institution.

The corporate board conducts most of its activities through a committee structure, and the key committees are planning, finance, religion, and health. These committees formulate most of the recommendations with management for the board. Our board does meet on a monthly basis, as our board members have a fair amount of demands on their time, serving on committees and on governing councils as well as on the board.

There is nothing particularly unique about our particular organizational structure. There is the president, Dr. Umbeck, and myself as executive vice-president. The line structure of the organization consists primarily of three senior vice-presidents who report to me. They are in operation, finance, and management services. Each of these people provides the key link between the corporate management staff and the individual hospitals.

Our finance activities are rather centralized in terms of accounting and financial control. We operate basically with a single bank account and with pooled cash concepts and allocation of capital based on need.

One of the things that is very clear in our organization and that is not quite so clear sometimes in other multihospital systems is the role of the administrator and to whom he reports. In our organization the administrator reports to the senior vice-president of operations and not to the governing council, and he has a line responsibility. At the same, he is also, if he is very smart, very responsive to the governing council and the local community.

Evangelical Hospital Association developed in such a way that it allowed the corporate board and corporate management staff to remain in control of the organization. As you examine other multihospital systems, sometimes you will find it difficult to understand exactly where the decisions are made and where the power is. Fortunately, in our organization that is clear. That does not mean that the hospitals do not have a great deal of influence and that the management of those hospitals is not given responsibilities and delegated authority. But it is clear in our organization that the board of directors in the system is in charge.

Each medical staff is separately incorporated within our system, and the reason is that, for the most part, the hospitals are not in the same service area. There is very little overlap between the medical staffs, even though we are in the same metropolitan area. We tie our medical staffs together through a medical affairs committee in which the administrators and the chiefs of staff of each hospital meet on a quarterly basis and look at major policy issues and major strategy issues for the organization. This is really a forum for corporate management to participate with the medical staff leadership and the administrators in dealing with activities and functions that are of a common interest to all of us. It has been a rather effective mechanism. I think in our case the decision for separate medical staffs was a very wise one and is serving us well.

The functions of corporate management within our system boil down to planning, resource allocation, and control. We do not view ourselves as operating five hospitals. It is the administrators who are responsible for the operation of those institutions. Corporate management operates a system of hospitals, and that is quite different from operating five hospitals.

In the planning area we have a corporate plan, a strategic plan that was developed about two years ago. It is currently undergoing a major overhaul and reevaluation. In 1981 each of our hospitals updated its own strategic plans. In our organization that is a bottom-up process. Our corporate plan guides and gives strategy to the overall system, and it also gives certain priorities and strategies to the individual hospital, but the planning process in our organization begins with very active planning input from the medical staff and the

board, governing councils, and management of each hospital. Those plans are then brought together, synthesized, and worked into the planning process again at the corporate level. That cycle goes on every two years.

We devote a fair amount of time, effort, and resources to strategic planning. One of our major functions at the corporate level, in addition to developing strategy for the overall system, is to insure that the hospital strategy will keep that individual institution competitive and postured in a way to meet the community needs for the next ten to fifteen years. So we place a great deal of emphasis on the generation of that plan from the local level, but it is done with the corporate planning staff assisting the hospital and it is given a very thorough review, analysis, and interchange from the corporate level.

In the area of operations, our hospitals report to a senior vice-president of operations, and his major responsibility is to supervise the management of those institutions and to provide backup, assistance, overview, support, and direction to the administrators. This is a very difficult and demanding job, probably one of the toughest in any system. The person who is the key link between those hospitals and the corporate management is a very crucial individual in the relationships between the corporate organization and the individual hospitals. The position takes a great deal of skill, experience, and leadership. Fortunately for us, Carl Zimmerman possesses those skills.

One of the functions that we think is important is resource allocation. We operate in a single corporation. We pool cash, and each hospital generates its capital request budgets, and those dollars are allocated back to the hospitals based on what we think is the best overall allocation for the total needs of the organization as well as of that hospital. Sometimes that process becomes a little arduous, but we attempt to go through it because we think it is important to the way our system functions.

Our two inner city hospitals are struggling and have a very, very difficult challenge to deliver health care in the inner city. They have a fairly high Medicaid and Medicare mix of patients, and in the state right now that provides some financial challenges. We subsidize the operation of those hospitals through earnings from the suburban hospitals. We happen to think that makes sense as long as it is kept within reason and as long as those inner city hospitals are meeting the kinds of objectives and needs that we think they should.

We are fairly meticulous in doing rate of return analysis on all capital expenditures. Not all of the decisions are made on that basis, but we attempt to use that kind of analysis to make sure that over the long term, the capital in our organization has been allocated in ways that will help assure strong fiscal



viability of the organization.

In addition to planning and resource allocation, we provide a fairly highly integrated array of corporate services to our hospitals. These services are provided to reduce cost, to supply expertise the individual hospital does not have, and in some cases, to exercise control over the institutions. They include a rather centralized financial system, a human resources program, small legal staff, planning, materials management, information systems, graphic arts, laundry. Partially centralized functions are development, public relations, facility planning and engineering, management engineering, information systems, some centralized laboratory services, and internal audit. Our system is probably more integrated and more centralized in terms of shared services than most multihospital systems. We have about 400 employees involved in our central services. Our corporate offices are located on a separate campus apart from any of the hospitals or other organizations we operate.

This differs from the situation at Fairview, which has its corporate offices located on the hospital of one of its campuses. Each arrangement has some advantages and some disadvantages. I am not sure it is important to the destiny of the organization, and maybe it reflects management style more than anything else. But if you are involved in a system and looking at that decision, it is not one that you make casually; it is one that you need to think through.

Let me talk a bit about the future. Our organization has been through a very rapid growth period. We are, for the most part, a horizontal system. We are operating mainly acute care activities. Over the next five years you will see our organization continue to grow and add other hospitals. I think we will add owned institutions, but very carefully.

We will embark on a managed contract division or activity, probably through a subsidiary corporation that we either acquire or develop ourselves. We will become much more aggressive in the area of ambulatory care and will also enter some other diversified activities, such as serving a very large laboratory market in Chicago, and certainly we will enter into additional elderly housing programs. Those projects in elderly housing can be done with a minimum of capital outlay and a minimum of risk, and the return from a social standpoint is immense. I would recommend that all of you look at the possibility of becoming involved in elderly housing.

In addition to how do we grow and what do we do with diversification, the real question for us is, Can EHA survive as an entity in this particular environment over the next ten to fifteen years? That may seem like a funny question. We are a \$273 million organization. We are relatively large as hospitals go, although not particularly large as systems go. Our return

is about 3.5 percent--not particularly good but probably better than most of you experience--and our cash flow is about \$14-\$15 million.

In spite of that, I do not think that EHA will survive the next decade in its present form. I do not think we will be large enough or grow rapidly enough, and I do not think that we will be able to maintain our competitive position.

We have some very key strategy questions in front of us. One of them is, Do we attempt to grow and develop and become a major factor in health care in the Chicago area, which is a very large market, or do we spread our risk and develop services in other areas and in other markets? That is a strategy question that on paper the board has already made--it has given us the green light to move out of the Chicago area. But when you really look at that strategy question and you look at what our organization is doing and where it is going, that is not an easy question for us to answer.

How much of our resources should we be investing outside the Chicago area, how much of our resources should we invest outside of acute care? Our target is 15 percent of our total resources in the next five years. That does not sound like much, but try growing some profitable businesses over the next years that will generate maybe \$50,000-\$70,000 in revenue. That is not easy to do. My guess is that we will do it more by acquisition than by growing.

In spite of that, I am not sure that we are going to make it, and so another question for us is, What linkages should we be establishing? What linkages should we be attempting to put together with Fairview and other organizations like it? Should we become more of a for-profit-oriented organization, or should we maintain our traditional Christian posture? Obviously we are going to maintain our values, but it is a question of whether part of our organization becomes much like a for-profit entity and operates in a for-profit mode.

Will we be large enough and smart enough, and can we deliver the goods? We will not be competing with only the for-profit system. We will be competing with entrepreneurial physicians. We will be competing in market segments in ways that we do not now understand because various kinds of enterprises are taking business out of our hospitals. We will be confronted with surgi-centers, family counseling centers, HMOs, and a variety of organizations. Where do we go, what kinds of decisions do we make now, and how do we position the organization so it can either survive or become part of an organization that will survive and will allow our mission to continue, that is, to provide health care in communities in which we serve as a representative of the United Church of Christ?

Let me share with you some scenarios that we have been looking at for the Chicago area. I think they will begin to give you an idea of not only the thrust of the investor-owned but of what is going on in Chicago and why we are asking these kinds of questions. The growth of the investor-owned and the kind of money they and insurance companies can infuse into HMOs really causes us concern in terms of our viability and strength over the next decade, but there are some other things going on in Chicago that also cause us concern.

Most of you know that Chicago is a metro area that is experiencing a decline in population in the city, some increase in population in the suburbs. We have seven medical schools in this metropolitan area and a large number of tertiary care centers, and we are beginning to feel a little impact from HMOs. As we look at the state of Illinois, which is having a very difficult time supporting its Medicaid program, we have seen decreases in per diem reimbursement for two years in a row. We are taking a beating of about \$100 a day in Medicaid care.

According to one scenario, in the next twenty years in the Chicago area, we will have a penetration of 20 percent by HMOs, and they will hospitalize patients at 800 days per thousand. If the rest of the patients hospitalize at 1,100 days per thousand and the length of stay goes down to six days (which is not too unreasonable if the government and other factors begin to continue to reduce length of stay), and we assume an 80 or 90 percent occupancy, which may be a little tough to achieve, some rather dramatic things happen in the Chicago area.

The need for beds in the Chicago metro area goes from 35,000 to 25,000 over the next twenty years, and that is including the population growth of the suburbs.

We think there is some possibility that that scenario might be played out. The question is, Whose 10,000 beds are going to go out of service? In the city of Chicago we have a situation in which most of the beds are either in small, fairly poor neighborhood hospitals or centered at the seven tertiary care centers. Depending on what the reimbursement people do, that will have a lot to do with whose 10,000 beds go out of service. We do not plan to lose some of our beds in that 10,000. But if you look at what is happening to the world at large, and then look at what might happen in Chicago, I think you can begin to understand why we are asking, How can EHA survive?

We think that we will, but we are not sure that we will survive in the form in which we presently operate. I think we will adopt strategies to find a way to link ourselves to other systems and to make sure that we are going to be competitive not only in Chicago but on a national basis.

CHAIRMAN MORTON: I propose that we take some time for questions for these two speakers in particular, and then the

reactor panel members will address issues raised in the entire symposium.

BERNARD J. LACHNER: This is a question for both Carl and John. Yesterday morning one of the speakers made the observation that he expected many nonprofit hospitals to become proprietary hospitals in the future because of the cost of raising capital. Has that ever been seriously considered by your institutions?

MR. PLATOU: The issue of the acquisition of capital is one of the key elements we all face, but in terms of the attitude that we would have, no, we would not change our characteristics to raise money. An organization like ours could own a for-profit subsidiary and control its stock, and then perhaps sell some of that, just as a church in downtown Chicago could have a parking lot and lease that lot out for five days a week and make proceeds and pay tax on that, but still remain a church. A nonprofit organization can have a profit involvement. We certainly do, and we could probably outperform those that are confined to the for-profit sector. We purchased a for-profit company with 115 specialists, a management company called Brimm. It has been an extraordinarily successful relationship. They have outperformed what we could do with our own people in the same function of management of other hospitals. So we have had a tremendous acceleration of growth.

All that stock is held by the Fairview Community Hospital. Whether we use that as a platform for capital acquisition in the future remains to be seen. It is a distinct possibility, but it will not fundamentally change us.

MR. KING: Just a short answer from our standpoint. I think that if the policies that are adopted by the reimbursement agencies, the federal government in particular or the state, create an incentive for our organization to operate its hospitals in a for-profit corporation, we would probably organize in a for-profit organization and put the stock in a foundation or some other controlling agency that the church would have an opportunity to exercise some control and influence over. We would maintain the characteristic volunteerism that we have had historically but would combine it with the financial advantages of a for-profit entity.

MR. PLATOU: We have a \$5 million a year for-profit business, our MIS center. It started in the hospital as a small IBM 1440 computer sixteen years ago. It has grown into a big enterprise and sells to hospitals plus other organizations.

MR. KING: Bob, the thrust of your question obviously is directed at the problem of capital, and I would certainly be the first to admit that that will be a problem for us. Whether we are for-profit or nonprofit, I definitely think that we will be a lot more leveraged ten years from now than we are now, and

that will be a limiting factor for us. I think that is one of the things that will start to bring systems together and spur the creation of new organizational formats as vehicles for capital formation.

CHAIRMAN MORTON: Are there additional questions?

MICHAEL J. EBERHARD: Yesterday we heard from Joe Hutts of HCA. He mentioned that in the last twelve months, HCA has raised \$1 billion. I do not see how we can compete with that. Although I can see opportunities in investment areas and we are pursuing some, that seems of such a minor dimension when you look at a company that in twelve months can raise \$1 billion and put it to use in developing their hospital system. Do you have any comments?

MR. PLATOU: You are raising a key point. How do we compete against a billion-dollar corporation? But it is a large country; there are a lot of needs out there. I would not be one bit intimidated by them. The issue is, How do we improve our own performance?

John is absolutely right. There will be 10,000 fewer beds operating in this community. We have in our community one hospital that last year lost a million three; others have lost a few hundred thousand dollars. What does it mean? They will be forced to look at alternative answers in the near future.

The point is that this is the best time to be in health care because the opportunities are great. The investor-owners do not have an easy time of it: they have the severe discipline of performance on stock. It isn't all one sided; no one should stampede you into thinking that it is.

MR. KING: It seems to me that the penetration of the investor-owned companies will increase. In the last five years, though, we have seen investor-owned companies behaving more like nonprofit hospitals, and nonprofit systems behaving more like investor-owned companies. I think the investor-owners are acting much more responsibly than they ever have in the past, and we are becoming much more entrepreneurial. It is possible that over the course of the next decade, it will begin to be difficult to distinguish between the two in some ways.

Public policy and the marketplace dictate that over the course of the next decade, the next fifteen years, there will be six to eight major national health care appropriations in 80 percent of the hospitals. So be it. If the public is served by that, fine. And if you are a free-standing hospital and that bothers you, then you have to take Carl's advice: Either keep peddling your bicycle the way you are or you do something about it. I do not think we can just sit around and worry because as we are worrying, the world goes on.

I think it is primarily a marketplace and public policy issue, and unfortunately, the nonprofit hospitals in this country do not have much influence on public policy. But those are the areas--public policy and marketplace--that will have to be addressed.

DONALD CORDES: It seems to me that some interesting comparisons have been made here. Hutts told us yesterday about the HCA organizations. Although some corporate disciplines are imposed on that system, he went to great lengths to emphasize to us the independence asserted by the individual hospital operator. That may be questionable, and certainly there is pressure to keep the stock price-earnings ratio high, but the management style is what I want to get at.

John, if I understand you correctly, you have an overall CEO, executive vice-president, the senior vice-president for operations, and administrators of those hospitals, so they would consider themselves at least four levels removed from the central authority. Carl, if I know your system, you give a good deal of freedom to the individual administrator by giving him guidance more or less as he calls for it, although you expect, I am sure, good performance and results.

I would like you to speak to the issue here of governance and what it does. I would think, John, that you would have a little trouble getting real entrepreneurial administrators if they felt that they had three or four levels of authority to pass through before they could make a \$50,000 decision on capital.

MR. KING: First, if an administrator has a capital item over \$50,000, he does not have to go to four levels. The senior vice-president makes that decision up to \$150,000, and I make it above that. The decisions on over \$150,000 for capital that we make in our organization are a handful, so he really has to go only one level for almost everything.

Second, our organization is in transition and planning for Dr. Umbeck's retirement. Our organizational structure partly reflects that. I do not know if we will have those four levels in the future, but we are building depth in our organization in order to provide an orderly transition.

Third, in terms of the roles that we have ascribed to people, Dr. Umbeck's role in our organization is development and planning, and it is his job to move the organization left, right, or forward. I play a part in that, and I am really the bridge between that development and the operations. There is no way that a person who is responsible, as I am, for finance or corporate services as well as the operating entities can do a good job of relating to and supporting those five administrators, so we have a senior vice-president of operations.

We probably tend to have more corporate services and more centralized direction in our organization than some. Traditionally in our organization the administrators have not played as strong a role as have those in the Fairview system. That is an accurate evaluation, but we also have 1,600 beds in a given metropolitan area, none of them more than thirty-five minutes from the corporate office, and that provides us with an opportunity to do some things that other systems which are more spread out geographically cannot do. As we become geographically dispersed, we will operate differently. There is no question about it.

Also, our development has taken place in five years, whereas some of the growth that Carl is talking about has taken place in fifteen years, and so we have not built the kind of infrastructure in management that he has. So there definitely are differences in the way we operate, although in the two years that I have been on board we have consistently been delegating more responsibility and more decision making to the operating units in anticipation of future growth.

So our management style is a product in part of philosophy, geography, and our stage of development.

MR. CORDES: Does it influence your effectiveness very much?

MR. KING: If I knew how to measure that, I would tell you. Some things it does influence and other things it doesn't. We have been working in our organization to get our administrators to take more initiative and responsibility because traditionally that has not been expected. We are expecting more of that, but on the other hand, we do not get involved in medical staff affairs, we do not get involved in local issues. But we do know what is going on in the hospitals. We do not make operating decisions from Oak Brook.

MR. PLATOU: In part we are products of the influence of people on our boards and in our communities and of our own attitudes and personal philosophies. Two men have very much affected things at Fairview. One is Donald Grandgaard, vice-chairman of our board and chairman of the First Bank System. The First Bank System is the Ninth Federal Reserve District and is the largest bank holding company there and about the sixth largest in the United States, with ninety-seven banks. Grandgaard is a brilliant fellow. He manages that bank system with ninety-seven bank presidents and a whole support system, and he describes the holding company as a rising horse with a loose rein. He advocates the recognition of problems, determination of solutions, and taking action at the level of the local bank board and its president. It cannot all be done in a given corporate tower. Some bank companies do that, but they do not succeed as well as those that have a more entrepreneurial approach.

Another member of our board is Lou Laire of 3M, which is actually forty-six operating companies. Lou would be the first one to tell you that their new product development comes not from their corporation office or a central planning process but from what they call the field force, something like the corporation's "grass roots."

The for-profit organization's discipline is the stockholders. Although we nonprofit organizations resemble the for-profits in many respects--we have our strategies, our "return on investment"--we have a different mind-set. That is why health care is difficult: We have a mixture of responsibilities. Our first responsibility is to our patients and our community. Although finance is crucial and affects our organization's structure and philosophy, our first responsibility is not financial.

MR. KING: I want to add that HCA is only one example. The for-profits are not all the same. In the industry HCA is known as the organization that gives more freedom to their administrators than do most companies. At Humana there is a different environment, one in which the administrators have less freedom. So within that arena there are different styles and different methodologies. Humana, for instance, was basically developed by a group of attorneys, and I think it reflects their management style. HCA developed with physicians on its board and in management, and they understand and value the local hospital and its medical staff relationships; thus they give more freedom and more latitude to their administrators. In addition, as nonprofit systems develop, their structures and sometimes their styles change.

As our system becomes involved in more diversified activities, it will have different divisions or companies which do different things, and they will relate to our corporate management in ways which differ from those of the hospitals. If we acquire hospitals outside Chicago, they will relate to management differently than our five do today. And as our system diversifies, our five hospitals may have a different relationship to our corporate office.

Different styles can be equally successful. But certain things are necessary. For instance, if you have a system such as Fairview which gives a great deal of autonomy to the administrator, you must have people who can act on their own, and if you have a system like ours that holds them a little closer, you must be sure that you do not have people in those positions who are constantly chafing under that supervision and want to be free-lance artists. So you have to match your people with your style.

While I am on the subject of the kind of people you employ, I want to add that not all the people in the corporate office need the hospital administrator background. For example, our



financial officer is from industry, our corporate services officer is an attorney. That kind of mix and blend is very important in our kind of an operation because we are not running a hospital but a system, and it is a very different environment.

ROBERT COLLETTE: To what length is EHA willing to subsidize its two inner city hospitals? You paint a fairly grim view of the future. Would you ever let them threaten the organizational viability, and if you stop providing them services, who will take up the slack?

MR. KING: Some people think they are threatening our viability now. That is a very difficult thing to evaluate and has to be done almost constantly. After a couple of years of hard work, those two institutions were operating at almost a break-even point in 1980. However, the Medicaid situation changed in the state, and both of them are going to sustain losses this year of probably in excess of a million and a half dollars. We think we can sustain that kind of a loss for a period of time. We also have a new construction program at Bethany and are rebuilding that facility; obviously we have made a commitment to hang in there.

Part of that will depend on the viability of the rest of our organization. If the rest of our organization continues to grow and to be financially healthy, we can, theoretically, sustain those two institutions for a long period of time. The difficulty with that is, you set up within your organization some tensions that are hard to live with and endure over a long period of time; it is a very simple matter of how long the medical staffs in the suburban hospitals will accept their cash flows' moving into the city.

Our particular organization is committed to providing health care to Chicago. It is not locked into providing health care in those two hospitals forever. But it is committed to providing health care in the city, and I do not know what form that will take over the next ten or fifteen years. There is a reasonably good chance that in another two or three years the Medicaid, inner city situation will improve here, and we will probably try to make it through that period.

However, the challenge is not to keep subsidizing those hospitals but get them on such a financial footing that they can sustain themselves. That is our real objective.



## REACTOR PANEL

## Speakers and Faculty

Reed L. Morton, Chairman

PARK DAVIS: One of the questions that emerged in the discussion is, What will happen to the inner city hospitals over the next ten or fifteen years? How many will form an alliance with other organizations? How many will perhaps remain independent organizations, and what do you think their characteristics will be?

RICHARD W. FOSTER: John King is right; he can hang in there for a while, but ultimately there must be restructuring, and ultimately that will happen. However, in the meantime there will be much pain and grief, and I do not think that affiliating with other hospitals will change that situation and bail out inner city hospitals in any meaningful way.

CARL N. PLATOU: I will differ with that because of one fundamental point. The predicament of the board of the inner city hospital and its medical staff is in large part a reflection of their kind of thinking and planning or lack of planning over many years. They have certain problems--deteriorating neighborhood, local income level, physicians' offices moving away, and so on--and the ability to think through them and examine a new future is hampered because the board and staff members are victims of their own thinking.

The affiliation, association, consolidation, whatever you want to call it, has more than economic value: it can provide the intellectual stimulation for an examination of the future. The association offers more resources for thinking about the present and the future than the individual hospital board, its administrator, and its medical staff has had in the past. Evaluating strategies with others on a continual basis tends to improve the situation.

DONNA I. REGENSTRIEF: The question is impossible to answer as it was phrased because inner city hospitals are not a homogeneous entity. First, there is the geographic aspect of being located in the inner city, for whatever historical circumstances. We all know that what used to be an inner city might be the new "hot" place to live in a community, so even being in the inner city is something that might not mean the same thing ten years from now as it does today.

Second, there are inner city hospitals that are municipally owned and operated and that therefore might reflect the issues of politics and the patient-management-labor situation vis-a-vis municipal governments. There are inner city hospitals that are essentially voluntary community hospitals, very frequently not-for-profit, with church-related missions or other types of

goals. Then there are inner city hospitals that are tertiary care medical centers, and this is certainly true of Chicago, New York, and Detroit, and some of the Boston hospitals.

So I think that the only way you can reasonably answer that question is on a population basis regarding the kinds of health care needed, the people who are served by the institutions, the needs, the demographics of these people.

As for John King's question about which 10,000 beds will go--my answer to that is, whichever ones are not needed. One need not necessarily determine which are the best institutions or have the most political clout or economic viability or ability to raise capital and so on, because the final issue becomes one of rationalizing the financing to pay for the care of the people who need the care and whom our society has determined will be cared for. Some kind of rationalization on a beneficiary basis will be the determining factor of the financial viability of inner city institutions--whatever their governance, whatever their mission and goals. Given that, I think those institutions that are most effectively managed and run, not necessarily financially but clinically, so they can provide a more comprehensive package of services to a larger population at risk or in need of such services, will be the survivors.

ALEX HARMON: I would like to add to that a couple other aspects of the inner city dilemma.

There are small inner city hospitals that are not going to make it--they are too inefficient, they will have to either close or merge. I think the successful inner city hospitals will become larger and survive because of economies of scale.

Unless there is an unexpected reversal or change in the direction of social policies, there is the danger of the two-tiered system of health care, in which there will be one system of care provided in the private sector and another reemerging in the public or tax-supported sector. Whether there will be separate institutions, I do not know, but I think the level of care in each may not necessarily be the same. Perhaps the quality of care may be comparable, but I think the amenities of care will differ because if the public which controls the resources for public care must limit or ration those resources, then the services will be rationed.

Multihospital systems are an attempt to enlarge on the leverage and effectiveness of health care systems. I think they are very encouraging developments. I think the next ten or twelve years will provide exciting opportunities for the younger managers coming up, who will need to be tough, creative, and full of ingenuity.

ROBERT A. DeVRIES: I thought perhaps it might be useful to react a bit to some of the papers in terms of identifying five or six issues I think we have not looked at and really need to look at with regard to multihospital arrangements, multiinstitutional systems.

I do not think we have begun to deal with the manpower question in terms of how we prepare the future executives, the top management team of these systems. Few graduate programs in the United States and Canada have a reasonable component in their graduate curricula that addresses the multihospital systems and the differences in knowledge and in skill that will be required in the future. That is an area of deficit.

The second point has to do with health professions' education. The investor-owners have not participated to any significant extent in graduate medical education or in the preparation of health personnel, and I think that as the investor-owners continue to grow and there is a press in this country in terms of education, formal preservice education, something has to give. The investor-owners will be pressured to take a stand, to either participate or make it clear that they will not participate in health professionals' education.

It seems to me that hospitals represent one of the largest educational systems in this country. A great deal of education--both formal preservice and continuing professional education--goes on in the community hospital and the medical center, and I do not see how that will be sorted out, particularly in terms of the role of the investor-owned firm.

A third point involves governance. I do not believe we have scratched the surface with regard to the governance of hospital chains and systems. I think the idea of the professional hospital trustee, the professional systems trustee may have some potential. It seems to me that several of the systems are paying attention to this or are identifying people with specific skills or background who are working as trustee consultants on an ongoing basis in the areas of finance and labor relations, to name two.

The final area has to do with quality assurance. We continue to look at and to practice quality assurance methodology on a unit-by-unit, hospital-by-hospital basis, and I would suggest that we must deal with a systems approach to medical quality assurance, medical auditing, in the future. For instance, are we to restructure voluntary accreditation, facility accreditation, because of the emergence and the tremendous growth of hospital systems?

I just offer those points as holes in the road that need attention as we continue to explore the growth of the multis.

JOHN IMHOFF: This relates to the marketing issue: What do you think the future holds for multihospital systems in terms of formal affiliation of subscribers or consumers? I emphasize formal.

MR. PLATOU: That is currently an issue in our community. A few months ago our organization conducted an experiment with the preferred provider organization concept, in which we took three of our hospitals and three in St. Paul, under different ownerships, and each put in the funding to start a PPO--which means, in effect, that we would go to industry and market medical and health care services in total at a highly competitive rate. It went along fine except for one hospital in our group, Fairview Southdale, where the physicians all paid for service and eight HMOs, and so this was a terrible intrusion on their democratic processes and they voted no. Now we have another medical staff that also voted no. So we tried to market a PPO, and we failed--but that is only the first time around. It is difficult, but it will come eventually. Therefore, I come back again to the issue that I tried to make in my comments. In this environment, a board of trustees must have the courage to serve as a board in other senses than that of "trustees." The board must concern itself with the development and viability of its hospital, which today involves risk--for example, to the medical staff--and going on the line for costs. It is a changing scene.

JOHN KING: I will respond to that and link it to the question about what is going to happen with inner city hospitals.

It seems to me that the future of inner city hospitals will be determined to a large extent by policymaking with regard to reimbursement for Medicare and Medicaid. The indications are fairly clear that organizations will have an opportunity to either bid for or capitate for defined populations of Medicare and Medicaid patients. Those institutions in the inner city that have high proportions of those patients will have to find a way to compete in that arena.

I think it will also begin to structure new relationships between tertiary care centers and community hospitals as those populations are being looked at, and I think the multihospital systems will definitely be aggressive in that area. Some of them have the advantage of geographic distribution, and they can put combinations of providers together in ways that free-standing hospitals cannot. So I think that some of the hospitals will be aggressive at that and at developing and executing strategies toward defined populations. That will be the important element within the inner city situation, and certainly I think it will be in Chicago over time if the state begins to move in that direction, as it appears to be doing at this time.

DR. REGENSTREIF: I have comments on the observations that were made about training programs.

We talk about academic medical centers as tertiary care medical centers, as if they do not do any primary and secondary care, when the fact is that the alternate tertiary medical care centers seem to have undergraduate medical education, clinical clerkships, and so on, as their major missions in addition to patient care service and research and clinical training of graduates. I believe it is the unusual medical school that graduates as many as 5 percent of its classes into clinical research and training and academic medicine, and the other 95 percent, if they are trained in tertiary care medical centers, are at risk for losing or never having found a primary care mission.

Many of our tertiary care medical centers have comprehensive care centers, primary care units, and do an excellent job at inpatient and outpatient care and at providing some of this training. But we cannot lose sight of the fact that the academic medical center provides primary care and secondary care and needs to form firmer linkages in terms of faculty and clinical training with community hospitals which specialize in the primary and secondary care, or the basic mission of undergraduate medical education will be eroded.

DAVID W. JOHNSON: It is my understanding that 70 percent and above of the money paid from the major third-party payers in this country is paid for the care of somewhere between 10 and 20 percent of our people who appear to have very serious illnesses. What changes are we proposing for the care of that fairly small proportion of our population which has those serious illnesses and injuries?

MR. KING: I do not have a very good answer for that, but I want to connect it with an issue kicking around in this state legislature right now regarding the free choice of physician for Medicaid. It seems to me that when we think about that risk group, and what to do about it, we run smack into the problem of free choice of physician and free choice of care. I think that is a major stumbling block in some ways and a major ethical and public policy issue.

DR. FOSTER: A large number of that small percentage of the population that uses a lot of medical resources does not consist of people with immediately life-threatening conditions; it consists of people with multiple chronic problems who are cycling repeatedly in and out of the system. Some kind of reorganization, I think, could have a significant impact on the expenditures and pattern of care that those people receive.

In the present context it raises an issue that came up yesterday, that is, by and large everybody seems to agree that cost-containment pressures are an extremely important part of

the environment and that a successful organization has to deal with that. I think it is clear that to deal successfully with that, you must influence physicians' clinical practice patterns. The problem is, as we have heard at this symposium, that we really have not affected referral patterns and we have not done much about clinical practice patterns.

MR. HARMON: To muddy the waters a bit more with regard to this issue, I want to express my concern that, in the evolution of these new organizational forms and the competition that we face from adventurous people in our business who see profit-making opportunities (be they for-profit, investor-owned or nonprofit institutions) we may lose sight of the fact that as we skim off the less costly and more lucrative types of services and categorize them in specialty organizations, surgi-centers, doctors' offices, small proprietary institutions of one sort or another, we will leave not only the inner city hospitals but also perhaps some of the more altruistic outlying hospitals a different kind of patient. This patient will be more expensive to care for. I wonder if those who control our reimbursements and our resources will appreciate and understand that there must be a recognition of the fact that patients with certain kinds of illnesses and social problems will have to be allocated resources in ways that are different from those we have now in terms of average costing.

DR. REGENSTREIF: I would like to comment on the composition of that population to which you are referring, presumably the Medicare and Medicaid eligible populations, and on the demographic features of the societies that are shifting.

A relatively little noticed phenomenon is the change in the population that is over the age of sixty-five. We have a tendency to think of Medicare and over sixty-five as a single group, but there are enormous differences in consumption of resources (both the acute and ambulatory care and the long-term care, institutional and noninstitutional) within that age group. The March 1982 issue of Health Care Financing Review has an article on changing patterns of acute care by the elderly and Medicare populations, broken down into age groups of sixty-five to seventy-five, seventy-five to eighty-four, and eighty-five and up. In the last group, eighty-five and up, I believe one out of four of those people is institutionalized in nursing homes. With every ten years of age, there is a doubling of the number of days of care.

The type of health service that one is eligible for under Medicare is acute care, and those people who have Medicare benefits become eligible for Medicaid, and the Medicaid budgets increasingly are going for elderly people who are also typically poor people but who did not necessarily start out that way--they just, in effect, outlived their resources. Our attitudes toward the types of care are bound up with social and ethical values as well as financial implications and require significant



rethinking. We will not begin to understand the problem if we do not sort it out better than we traditionally have done. Fifty percent of the New York State Medicaid budget, which is the highest in the nation, is consumed by long-term care, yet the image is that it is going to mothers and children on the sidewalks of New York. That is not really true.

MR. KING: Thus there is the question whether the decade of the eighties, in addition to being the age of multihospital systems, will be the age at which some very tough medical-ethical issues come into focus. Part of the difficulty is, we are not quite sure how an organization like ours, which is vitally concerned about some of those ethical issues, finds answers to them--or how the physicians or leaders of the hospital industry deal with them.

In addition to some of the questions that Bob listed for multihospital systems, I would add that multihospital systems have an opportunity to address some of their resources to some of these medical-ethical issues.

DR. REGENSTREIF: The focus here has been on how hospital administration educational programs and management programs can do a better job and remain relevant and current.

I am equally concerned about the opportunities in the medical educational curriculum for physicians in training or medical school students to be aware not so much of cost-containment aspects but simply of the issue of medical product and the macroeconomics of the medical system. This is important not so they can order one less laboratory test for their patient, substitute one for another, or set tests up incrementally, but simply so they can understand some of the linkages between their practice pattern and outcome for patients and cost. We are at the point where we need to begin making some substitutions, but we do not understand enough about what we are doing in terms of the products we are producing and what needs to go into them. We must be aware of where the substitutions are possible so that we can maintain the quality of the system while containing its cost. I am convinced that there is an implicit cultural norm in medical school according to which parsimony and effectiveness or quality are viewed as mutually antagonistic, whereas in every other science, parsimony is sought after.

ODIN ANDERSON: John King, you observed earlier that the differences between the nonprofit and the profit sector will diminish or blur. Would you elaborate on that?

MR. KING: Look at the history thus far: as Carl mentioned, when they began, the investor-owneds were regarded as the black sheep of the industry. However, today the black sheep have become the growth segment of the industry and have been legitimized on Wall Street. They have also to some extent legitimized themselves by improving the quality of care they

offer in their hospitals and improving the ethics by which they do business. There are still people on the nonprofit side who do not like the tactics that for-profit people use, but the fact is, the larger, more responsible investor-owned companies have become more responsible companies and they are in it for the long haul. I do not think that you will see Hospital Corporation of America go out of business or sell the business if profits diminish; they will stay with it. The investor-owned firms realize that, in order to make it and make it well in this industry, which is a service industry, they must give good service, and I think they are attempting to do that.

Their emergence in the industry is causing many other repercussions, but the fact is, they behave relatively responsibly. The problem is, sometimes people compare the for-profit industry with the nonprofits by juxtaposing the worst characteristics of the former with the best of the latter. That is an unfair comparison. You could take the best things the for-profits do and hold them up against the worst things the nonprofits do.

The point is to be more realistic and objective in comparing the two. I think that the for-profits are coming more to the center of responsible management and responsible business, and I think those of us who have been on the nonprofit side and have worn the white hats are beginning to see some soot on those white hats--maybe we have not been sufficiently entrepreneurial in our dealings, and we are beginning to act more so. Thus the distinctions between the two are becoming more blurred. The environment and the public policy are becoming such that the larger, more aggressive nonprofit systems and the investor-owned companies will need to become more and more alike.

That does not mean the whole industry will be made up of only those kinds of organizations. I do think they will dominate, but there certainly will be other kinds of health care organizations. I certainly believe that HMOs as we know them today are going to become dominant health care delivery organizations in the future, and they will be a third element.

BEAUREGARD STUBBLEFIELD: I am a second-year student in the program doing my practicum at Cook County Hospital, the largest hospital in the country. Many people do not realize that County also has Oak Forest Hospital, a long-term facility, and Cermak Hospital, a prison facility. There are also a number of city and county types of clinics. In a sense you could look at this as a system, although it is not currently being operated in one coordinated fashion. But it is possible that it could be. I wonder whether that is a serious option to consider, whether they will, in fact, become coordinated systems, operating to serve the inner city. And as a public policy question, who really should be serving the inner city populations--nonprofits, for-profits, on governmentals? Do they all have roles, and if so, what might those roles be?

DR. FOSTER: I do not think local governments will ever share enough to form systems that span several metropolitan areas.

MR. DeVRIES: There are some communities in which cities do operate hospital systems; New York City is an example. They don't enjoy a very high reputation, I am afraid. They have had very major money problems.

It seems to me that the public hospital system approach might be a reasonable one in a smaller city, where one can maintain a closeness to decision making, to policymaking at a city council level. But I for one would have great concern about the capacity and the opportunity to operate a reasonable public hospital system in a metropolitan community.

MR. HARMON: My own background involves a career with city institutions, and it has been a not-for-profit sector. I think it is possible, theoretically, for the not-for-profit or the profit sector to operate a system for the needs of the city citizens, the citizens who cannot afford their own care, who do not have their own resources. I think under contract we could do a far better job--more efficient, more effective, and of higher quality--than is being done by the public authorities.

The problem is, when the public authorities do not control the use of the funds that are under public domain, they have serious problems philosophically. So I think it will not be possible to operate and take care of the medically indigent or the poor out of tax funds without having publicly owned institutions.

In larger cities, such as New York and perhaps Chicago, there is a good case for operating them under a single combined system, but I do not think they will ever be as efficient or as effective as our nonpublic sector is.

CHAIRMAN MORTON: I would like to pose what may be a concluding question.

I think implicit in many of the discussions has been an emphasis on risk seeking, becoming more entrepreneurial, becoming leaders. What do you think the graduate programs should do to inculcate in their students an approach different from what has traditionally been provided?

MR. PLATOU: Your program here is not oriented toward institutional management but toward the understanding of management's issues, and I think that is the demarcation in my own mind. I am very impressed with students who are issue oriented and ask questions in terms of the capacity and abilities required to move organizations. A background in such things as social psychology is helpful when the problem is how to motivate and get organizations, groups of people, to think differently for new solutions. That is not necessarily

institutional management, but you need to have the skills for the management of the institution.

MR. DeVRIES: I quite agree with Carl's viewpoint. I strongly favor the general preparation of the manager, the generic approach to education and health care management, as opposed to one that is categorized or oriented to an institution or a subdiscipline.

On the other hand, I think that there must be a role and a connection for the graduate programs with the multiinstitutional movement, and I see that perhaps at two levels. One is to provide, through a separate survey course or as part of several existing courses, an understanding of what is different about systems and their presence, variety, and structure. This would take the form of providing information and narration.

I do not believe that individual skills or the manager's skills are that much different for running a multihospital chain, a dime store, a bank, or whatever. But I do think that some introduction to the multiinstitutional system within the formal curriculum is important.

The second level of contact, as I see it, is at the postgraduate level. I think the graduate programs need to relate to the Carls of this world and do a better job of connecting students to managers in order to develop the managers of the future. That may take the form of fellowship arrangements for people, people that are on faculty, who would be part of Carl's top management team for nine months. This would also include research. To my knowledge, few universities (only three in the United States) have involved themselves in any in-depth way in studying this thing we call a multihospital system, and so health services research is wide open in this field.

CHAIRMAN MORTON: Are there any other comments or any other questions? I would say that we have come to the end of this program. Thank you all for your attendance, and I thank the panel members for their participation. I look forward to welcoming you to next year's twenty-fifth anniversary symposium.

Thank you very much.

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