Organization for Ambulatory Care

A Critical Appraisal

Proceedings of the Nineteenth Annual Symposium on Hospital Affairs
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Introductory Remarks

CHAIRMAN RICHARD P. GUSTAFSON

Welcome to the 19th Annual Symposium on Hospital Affairs.

As was the case for last year's symposium, this symposium was planned by a Committee of the Alumni. Two important changes have occurred in the past year. Last year the symposium was planned totally by the Alumni. We like to think that we were so good that the faculty joined us in force this year. Credit goes to Joel May, Ron Andersen, and Rich Foster from the faculty and to Milo Anderson, Dan Ford, and Dick Wittrup for the Alumni.

Unfortunately, we could not have our Chairmen, Lad Grapski or Ron Spaeth with us.

A second change is that the committee has been expanded to deal with continuing education issues for the Alumni outside the symposium. We would like your ideas on that.

I'd like to recount some of the criteria that are used for the topics at the symposium:

1. Does the topic deal with a subject of general current interest and importance to managers of hospitals?

2. Is it addressable from a sound scientific or intellectual perspective rather than from a how-to-do-it basis?

3. Can a topic be cast in a framework which makes it of immediate relevance and usefulness to the registrants?

Today's topic certainly meets these criteria.

Ambulatory care was first mentioned in our committee from the academic perspective. The focus, from an academic perspective, is on the effectiveness of various models of ambulatory care and the effects various models have on hospitals and the populations they serve.

A second interest that was mentioned explicitly was that of HMO's revisited. For those of you who have attended symposia before, you know that the 13th Annual Symposium dealt with Health Maintenance Organizations. Upon investigation, one finds some interesting data on federally qualified HMO's, according to the Office of HMO Qualifications and Compliance. As of February, 1977, 86 applications representing 79 organizations had been received since the final regulations were published in 1975 and forty-two applications were in process. There are now 28 federally qualified HMO's.

Then we looked at our hidden agenda. We looked at health planning and 93-641 and find that three of the ten priorities for that legislation deal with ambulatory

The Nineteenth Annual Symposium on Hospital Affairs conducted by the Graduate Program in Hospital Administration of the Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on the University of Chicago's campus on April 29-30, 1977. 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 Nineteenth 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, Mrs. June Veenstra, and Mrs. Sharon Kulikowski who not only staffed the Symposium, but also are in large part responsible for these proceedings.

care-related issues, namely: the need for primary care in medically underserviced populations, the need for medical group practices, the need for training and more intensive utilization of paramedical personnel, particularly nurse practitioners.

We thought of the effects of the Public Law 94-44 as related to primary care and medical education. We thought of last year's symposium: *Survival in Utopia, Growth Without Expansion,* and its implications for the hospital. Then this week, the President's proposed caps on costs for hospitals pertain to in-patients but apparently not to out-patients.

With just this brief list of forces impinging upon ambulatory care, I think we can see the need for today's symposium to assess the relative strengths and weaknesses of ambulatory care in the total perspective as well as in individual models.

The first session will be spent with an overview of organized ambulatory care to better understand the over-all state of the art.

This afternoon we will deal with the case studies in ambulatory care to assess the relative strengths and weaknesses of various models. Tomorrow morning we will look at the incentives for hospitals. Hopefully, they will be positive and lead hospitals to participate in an ambulatory care program.

Ambulatory Care Today

DR. STEPHEN LOEBS

CHAIRMAN GUSTAFSON: The first speaker for this morning is Stephen Loebs, who is an Associate Professor at the Graduate Program in Hospital and Health Services Administration, Ohio State University. His specialization is in medical care organization and financing ambulatory medical programs, prepaid health plans, public policy and politics and health care.

DR. STEPHEN LOEBS: The program of this Annual Symposium always seems to represent the forefront of systematic discussion on the major problems or alternative solutions to those problems confronting the health care system in this country. The proceedings, as you no doubt know, are read carefully, and they have their influence in their own right in a variety of settings. It is not unusual for me to find on bookshelves of administrators and academicians the proceedings of these symposia in a very readily available spot.

In short, my judgment is that this symposium and the published proceedings are a significant contribution to the knowledge and understanding of relevant health care topics. I would like to add my congratulations to the faculty, to the Alumni Association and to the University for sponsoring this annual event. I am very pleased to be a part of it and to have been invited to participate in it.

Before I begin my comments on ambulatory care, I would like to add a personal note about my relationships to this graduate program. It seems to me appropriate since this is largely an Alumni-sponsored affair. While I am not an Alumnus of the Chicago Program, my professional career has been significantly influenced by members of the faculty and by Alumni. Let me share a few of those with you.

At the time I was making a choice of a profession while in undergraduate college, I had the fortune of attending a special conference for Hospital Administrators at Colby College in Waterville, Maine where the keynote speaker was Ray Brown. His comments at that conference and personal conversations which I subsequently had with him were extraordinarily influential in my decision to pursue graduate studies in hospital administration and a career in this field. Fortunately, I was able to share with Ray, before he passed away, the influence that he had in me in those early days. He did remember that conference, and so I feel that Ray Brown and what he represents of the Chicago Program were clearly influential in my decision to pursue a career in this field.

Secondly, I have a Master of Hospital Administration Degree from the University of Michigan which as most of you know is now directed by a graduate of the Chicago Program and a recipient of the Bachmeyer Award, John R. Griffith. John has been very influential in my career and is a very close personal colleague. I can testify that the University of Chicago has been influential in Ann Arbor and in other places as well.

Thirdly, I am now on the faculty of a graduate program at the Ohio State University which was started about eight years ago largely due to the influence of another Chicago graduate, Mr. Bernard Lachner. Bernie Lachner has had an impact on graduate education in our business in Ohio that is felt today.

Finally, my most recent activity with AUPHA or the Association of University Programs in Health Administration has been a member of a task force on education for ambulatory care administration which has been chaired by Joel May, the current Director of the Program at the University of Chicago. The task force has had a very significant and very difficult assignment over the past ten months, and I consider it good fortune to have worked with Joel. I want to take this opportunity to publicly acclaim his leadership on this task force. He has done a superb job under some very trying and very difficult time restraints. It has been a pleasure to work with Joel on that task force.

So I am pleased to be here not only because of the significance of this Symposium, but also because I hope you can understand that I feel that I have been influenced in many ways by this Program, its faculty and its Alumni.

The purpose of my presentation this morning has three parts. First, is to establish some boundaries around which the subject of ambulatory care may be

discussed. I would like to define some terms and locations where ambulatory care, and organized ambulatory care particularly, is provided.

Secondly, I would like to attempt to interpret the current environment as it relates to ambulatory care. What are the forces which are pushing or pulling us into more organized ambulatory care? And, I would like to conclude with some personal observations about what the future holds.

First, in regard to definitions, a distinction should be made early on between the term "ambulatory services" and "ambulatory care services". The former, ambulatory services, is a broad term encompassing an infinite variety of locations and arrangements whereby people obtain medical services without admission to a hospital. The most predominant type of ambulatory care has been the private physician's office. I expect that this will continue to be so for some time.

We are concerned rather with organized ambulatory systems. That is a more specific part of the total arena of ambulatory care. I would like to propose several definitions of organized ambulatory care.

In a very interesting article several years ago, one of the leaders in our field, Dr. Milton Roemer, offered a definition of organized ambulatory services which may set the boundaries for our discussion. He submits that organized ambulatory services occurred in a setting in which several health personnel collaborate and make decisions through some team process or as a part of an organized framework. And, where the services usually, though not always, are financed in a collectivized or shared manner. The emphasis in that definition is that organized ambulatory services occur in a setting where several health personnel are working together, sharing information and in some cases, sharing the process by which the setting is financed.

A second definition refers primarily to primary care. There is confusion in the literature in the distinction between ambulatory care and primary care. There are those who attempt to define organized primary care as the services which most people use most of the time. And indeed, there are some who suggest that ambulatory care is primary care.

They further suggest that organized primary care occurs at the point of first contact for people in the medical care system where assessment of their general health is made and where subsequent direction is given. I find that particular definition somewhat limiting. I think we are concerned with more than simply primary care or sites where organized primary care occurs.

I would, in fact, like to suggest somewhat of an eclectic definition of organized ambulatory services, it consists of several types of medical services. It is, of course, first contact medicine. It is also continuing contact. There is a longitudinal characteristic to ambulatory and organized ambulatory services. Still, the key of organized ambulatory services is that it has an integrative characteristic where there is team effort, a multi-disciplinary health team effort providing in one location a place where several health personnel and professionals may work together for diagnosis and treatment.

In brief, then, there is a distinct difference between the term "ambulatory services" and the term "organized ambulatory services". We are concerned with organized ambulatory services and not unorganized.

Given this definition, the next step I would see is to identify the specific types of organized ambulatory services in this country.

The special task force on ambulatory care of AUPHA which I mentioned a moment ago has recently concluded its efforts to identify the major sites of organized ambulatory care. There are 11. I would like to list them for you and subsequently describe them very briefly.

Those 11 sites, or if you will, 11 examples of organized ambulatory services are:

1. fee for service
2. group practice medicine
3. prepaid group practice plans
4. hospital based out-patient department and emergency services
5. community health clinics
6. community health centers which are also neighborhood health centers
7. school and university health care programs
8. health department clinics
9. home health programs
10. family planning clinics
11. industrial clinics and ambulatory surgical centers

This may not be an exhaustive list of the various types of organized ambulatory services, but it does cover the major forms of organized ambulatory services present in our country today.

Let me elaborate on several of these so that we have some feeling of the size and scope of these 11 examples.

As an example, an estimate of the number of fee-for-service groups by the AMA and by the MGMA

the family planning clinics and the industrial clinics, all of which provide ambulatory service. Also, I mentioned the ambulatory surgical centers as another form of ambulatory service.

The major forms of organized ambulatory service, however, seem to me to be the following: the fee-for-service groups, the prepaid group practice, HMO's, the hospital-based outpatient departments and emergency services, and to a lesser extent, the community health centers and the health department clinics. In other words, of the 11 organized ambulatory services that I mentioned, it appears that we are really talking about five as holding promises in the future for providing more ambulatory service on an organized basis.

I would like to turn to some comments on the forces that seem to be present for more organized ambulatory services. While we have listed the various alternatives, what is out there which is pushing or pulling us to consider more forms or more availability of organized ambulatory services?

I would like to suggest seven sources for change. First of all, there appears to be a real demand for consumers for organized and very centrally located ambulatory services. I was interested to read just recently that a survey which was sponsored by the American Hospital Association revealed that two-thirds of the ambulatory public regard the hospital emergency department as being interchangeable with a physician's office. The main reason why people appear to be preferring the emergency rooms over the physician's office is that they believe that the hospitals have better treatment facilities than physician's offices.

This has very interesting implications for the increasing demand from people for more centralized, more organized, and if you will, more comprehensive services in one location. There is other evidence to suggest that there is an increasing feeling among the community for organized ambulatory services. The data that you have all read in regard to the increasing use of emergency rooms is an example.

The second source is one which is receiving substantial attention these days, and that is the acute cost increases for inpatient hospital care. This is the number one topic on the agenda across the country, at least it appears to be the number one topic. There are substantial pressures from several different sources to do something about the acute cost increases in inpatient care.

One of the frequently mentioned alternatives for inpatient care is, of course, organized ambulatory services. That is the President's message and in state legislative proposals. It is obvious then that there are pressures for more organized ambulatory services due to the acute cost increases. I don't want to belabor that point. You are familiar with it, but it clearly is a source of pressure.

A third source of pressure for more organized ambulatory services is coming from the public but being directed through third parties, the private insurance agencies.

There is both public and private pressure on Blue Cross and Blue Shield specifically to change and expand their coverage to include ambulatory care. Historically, they have not been interested in or at least have not included comprehensive ambulatory care in their benefit packages. But, there is in a variety of situations and states pressure being brought on both of those major third parties to expand their coverage.

In the State of Ohio, for example, there is a legislative mandate on both the Blue Cross and Blue Shield Plans to expand their ambulatory coverage. If they don't do that, then the state government is likely to deny requests for rate increases. There are also pressures coming from private sources, namely the large employers who faced with increasing costs of health care for their employees want the most efficient and effective alternative at the bargaining table and in a variety of other means the employers are bringing pressure on both Blue Cross and Blue Shield to expand their coverage.

If they don't expand their coverage, then the employers should opt for self-insurance, which is clearly a source of pressure felt by some Blue Cross and Blue Shield executives.

A fourth source of pressure is a sense of change in the competitive environment for health care. We have only begun to hurt. We have only begun to be educated by the Federal Trade Commission in regard to what they can do to expand the possibility for competition among health care providers. The findings of the Federal Trade Commission in their publications have already had some impact. There appears to be a relaxing of the restraints on advertising. This could have a significant impact on ambulatory care, particularly if it can demonstrate more efficiency and less cost.

A fifth source of pressure is the presence of health maintenance organizations and their demonstrated

performance indicators. Every metropolitan area in the country, with a couple of exceptions, now has a health maintenance organization in operation. It appears as though those health maintenance organizations are having an impact on their communities and on hospitals which are being faced with comparisons.

They are having impact on Blue Cross and Blue Shield Plans which are being faced with comparisons on premiums. They are presenting to people an interesting alternative.

While the growth in the number of enrollees is not significant over the past two years, there is some evidence that the HMO's are having impact on existing providers which could cause them to expand their ambulatory care programs.

A sixth source of pressure appears to be the impact of the PSRO's. They are only beginning to be activated around the country, but where they have been activated and where they have begun work, it appears as though (at least from informal conversations), they are having some impact on rates of utilization to the extent that some hospitals are feeling a decline in their occupancy. One of the responses to that decline in occupancy is the development of ambulatory care programs to serve as feeders for their census as well as provide a source of revenue.

Finally, a source of pressure is evidence that organized ambulatory services do provide some interesting impact on outcome of health status. Studies have indicated that comprehensive ambulatory services provided, especially for the low-income population, do improve health status measured by either morbidity or mortality rates.

So it seems to me that we can identify at least seven forces for more organized ambulatory services.

However, there are problems. I would like to turn now to an identification of three major problems in the development of more organized ambulatory services. Those three problems I will classify as leadership, financing, and demonstrable effectiveness.

First, is leadership. There seems to be a significant question as to who is going to provide the leadership in the communities, and in the states, and perhaps, in the nation. Who is going to provide the leadership and take the initiative to develop organized ambulatory services and to stimulate expansion of those that exist?

From the record, at least, health professionals and particularly doctors, do not appear to be the source of leadership for organized ambulatory services. In many communities Hospital Administrators are under constraints imposed in part by their medical staffs and in part by the financing environment. These constraints retard them from fostering and providing leadership for ambulatory services.

Although the health planning agencies, the health systems agencies, do have a mandate to expand ambulatory services, their particular power in communities is yet to be seen. Perhaps they will provide the leadership. Some are very optimistic and some are pessimistic, but certainly the leadership there is uncertain.

The leadership from the third party agencies appears to be hesitant. There are certain third parties, particularly the Blue Cross Plans, that are assuming leadership roles, but in many respects I don't see the third party agency as taking a leadership role.

In other words, what I am saying is that the absence of significant leadership for expansion of organized ambulatory services and leadership to continue those that are in existence is a major problem. I am not certain, at least from my observations, where that leadership is going to come from.

We ought to address that particular problem and determine who should and who can provide the leadership in this important area. It may be that either state governments or the Federal government are the only and perhaps the best source for leadership.

The second problem is financing of ambulatory care. There are substantial numbers of people who remain uncovered by either public or private insurance programs for ambulatory care. There have been some very good pieces published in the literature explaining this particular problem. I recommend a particular article by Mr. Robert Blendon of the Robert Wood Johnson Foundation published in *Medical Care* not too long ago in which he lays out very clearly the financing problems in ambulatory care, particularly as it applies to the low-income population groups.

The essence is that Medicaid is not a financing program for all low-income people. It is a financing program for largely those on welfare. Yet, there are a large number of people who simply are not eligible for Medicaid. Further, Medicaid programs in many of the states do not cover comprehensive ambulatory services, and as you may know, in many states the benefits in the Medicaid programs are being reduced

because of the cost spiral confronting state governments which could make the problem of financing organized ambulatory services for low-income people more acute.

In addition, as I have mentioned earlier, private insurance plans only recently have begun covering comprehensive ambulatory services. In many states and communities private insurance is just not available for comprehensive ambulatory services. This is a particular problem because the relationship between financing and organization in ambulatory services is a very tight relationship, perhaps more tight than any other aspect of our medical care system.

So a major question is: How do we encourage institutions and organizations to expand their capacity to provide ambulatory care services in a financial climate which is not very encouraging at the moment and in many respects is not adequate to sustain new program development nor to sustain the costs over time of ambulatory programs.

Financing, then, is a major problem simply because of its absence.

The third major problem is the demonstrable effectiveness of ambulatory care and comprehensive care programs. While it is apparent to those who have studied the various alternatives for organized and comprehensive ambulatory care that there are demonstrable advantages, these are not always accepted by the consumers and the community at large. For the organized ambulatory services to be effective, they must attract customers, and they must attract people who can pay.

While the hospital emergency rooms have no trouble in that respect, other forms of ambulatory care do not hold as much promise. The community health centers, for example, clearly must expand the service space which they have had historically in order to survive financially. That means they must attract a broad mix of the population in terms of income, geography, race and sex. In order to do that, they must demonstrate their effectiveness for all kinds of people. They are having difficulty doing that from the information that I have. The health maintenance organizations must demonstrate their attractiveness and their effectiveness to large population groups, and some have had difficulty doing that.

If we remove the financial barriers or the fiscal problems, that is by no means a guarantee that we will have more use of organized ambulatory services. That is no guarantee that they will replace existing sources. The marketing problem is apparent, and it is becoming more recognized.

In conclusion, let me make a few further observations. It seems to me that the public financing mechanisms for organized ambulatory services are not a significant force for expansion of ambulatory services on an organized or comprehensive base. The neighborhood health centers now known as community health centers appear to be facing increasing difficulty in financing their operations. HMO support has leveled off and Medicaid financing is being cut back in many of the states. At present, public financing mechanisms are not encouraging development of organized ambulatory services.

Second, private financing mechanisms may hold the best hope for expansion of ambulatory services, but it is not altogether clear that they will be able to deliver. The private financing mechanisms might expand the availability of ambulatory care alternatives sponsored by hospitals and other organizations. But until that occurs, it appears we may have reached a plateau of development.

Third, the impact of HMO's could be much more significant than it is at the present time. But, again we may have reached a plateau in the number, in the membership, and perhaps, in the impact of HMO's. As all of you perhaps know, they are extraordinarily complex to start. They are extraordinarily complex to manage and very few people in the country know how to do one or the other. That, compounded with the problems that the HMO Act itself has had in getting under way and further compounded by the limited funding that is now available for HMO's development, suggests that we may have reached a point where HMO's will not be as significant a force in change as its advocates may wish.

Finally, what can hospitals do? While it is obvious that hospitals will be expected to deliver more ambulatory care, and while it is obvious that the hospitals' development of ambulatory care programs will be a primary determinant of their success in maintaining levels of revenue, it is not altogether clear that hospitals will be able to respond.

The absence of a solid financing base, the difficulty of managing hospital-based ambulatory programs and the difficulties of attracting new clientele all suggest that hospitals, with some well-known exceptions, will have difficulty expanding their activity in ambulatory services.

My conclusions are that the future developments for organized ambulatory care are uncertain. I would like to be optimistic, and I would like to suggest that we are fast approaching a point in which there is a comprehensive rearrangement of ambulatory care, providing more organized, more comprehensive ambulatory care services to the population. But, the current trend is not clear.

The View From Washington

MR. STANLEY S. WALLACK

CHAIRMAN GUSTAFSON: The next speaker is Stanley S. Wallack. Mr. Wallack is Deputy Assistant Director for Health Income Assistance in Veterans' Affairs, the Congressional Budget Office of the United States Congress. Mr. Wallack.

MR. STANLEY S. WALLACK: I would like to tell you a secret: there really is a strategy in Washington with regard to over-all health policy. It was unveiled this week. You have seen initial portions. There are people in Washington who have a master plan, which they have been working on a number of years. There is a strategy room at HEW in a new building on the top floor which we are just starting to unveil.

You shouldn't feel bad if that is a secret to you. I think there are an awful lot of people in Congress who don't know about it, and an awful lot of people in Congress who must know about it if anything is to happen.

Another problem is that a lot of bureaucrats don't know about it because the new administrators coming in haven't told those who will have to carry out the new policies exactly what they are.

It seems clear that in Washington a consensus must evolve before major policy changes. That requires the effort of people in the congressional staffs, Congress and the Administration. There have been massive changes in the last few years. Therefore, it is very hard for a place like Washington to have a strategy in anything.

Let me start off giving you some of the problems with the Congress and the Administration.

First, it is clear that there is no one voice in Congress. There is no one person who sets policy or who initiates major reform. The Congressional Budget Office is assisting the Congress in thinking about major reforms, specifically welfare reform and national health insurance. The Congress will have great difficulty trying to come to a consensus on a major public policy issue. That is simply because there are 535 members with very different points of view.

In the health area the problem is compounded by the number of committees who are making health policies. In the Senate and in the House there are committees authorizing legislation, and a committee in each for appropriations. They just don't agree very often. In fact, there is quite a bit of disagreement between the players. Over the last few years, the authorization committees have written entitlement legislation in the hope that the appropriation Committees would limit the dollars spent. (Entitlement legislation is when Congress passes a bill, and somebody is automatically entitled because of age or other criteria like Medicare.)

Thus, many new legislative issues are coming out as policies and are not being reinforced by either the Appropriations Committee or by the House Ways and Means and Senate Finance Committees.

This difference causes great difficulty in the Congress, I will go into this in more detail as it concerns the development of a comprehensive strategy in ambulatory care.

I will talk a little bit more about the Executive Branch later, but it's clear that today's group and the people who are now running HEW are going to set policies which are different than the people who were around with Ford and Nixon. Some of the policies that have been revealed are quite different.

If one looks at the three initiatives that came out in the Carter Budget, one should view them as only a preliminary statement. The new cost containment provisions reflect much more of a consensus than other proposals, at least consensus among bureaucrats who have been in legislative policy and others who have been in Washington a number of years. As you all know, these provisions resemble Phase 4 in many ways. It seems the resource people involved in this are those who wrote Phase 4 and other legislation.

But two other pieces of legislation seem to me to be quite different. One is the Child Health Assessment Proposal which is really an upgrading of EPSDT. The other is the reimbursement of physician extenders.

These are new proposals which represent the fact that different people are now sitting in the major policy situations in HEW and the White House.

Let's first talk about Congress. From the end of World War II, 1947 to about 1971 and 1972, if there was any strategy at all in Congress, it was expand.

Expand to provide increased access and to make medical care available. From 1972 until today there really have been no new efforts for substantial growth. It has been more of a containment strategy. Basically, I see the Congress looking at what they have done already in light of federal budgets and saying, "If we just let the system go, we are spending an awful lot of money." That is frightening enough and adding national health insurance is extremely frightening.

Let me give you an idea as to what has happened to the Federal Government in health. In 1970 the Federal Budget in health was about $16.6 billion. About $10 billion of that was spent in Medicare and Medicaid. In six years the Federal Budget in health went to $39.9 or about $40 billion, and Medicare and Medicaid went to about $26 billion.

From 1976 to our projections for 1978, Medicare and Medicaid will rise from about $26 billion to about $37 billion. In two years that would be an $11 billion increase. This coming year, without any changes in the cost containment provisions in Medicare and Medicaid, the increase in those programs will be roughly $6 billion.

Now that's equal to, if it doesn't exceed, the rest of the Federal government's role in public health services. That is including NIH, including all the service programs, all the immunization programs, everything the Federal government is doing. That increase alone, that one year annual increase in Medicare and Medicaid of about $6 billion dollars is equal to all other programs combined. It is difficult to make major new initiatives when costs are growing so rapidly.

We all know what the Federal government has done in the last five years they have focused on hospitals and tried to contain their costs. The reason for that is relatively straightforward. If you look at Medicare and Medicaid federal health expenditures, hospital costs represent about 60% of the total federal dollar. Medicare really emphasizes institutional care and acute term hospital care.

Three programs were developed in the last five years to control costs. One was the health planning legislation, aimed at developing certificate-of-need programs in every state. The development of PSRO's was an attempt to control utilization and bear expenditures. There have also been attempts to try and change the way we reimburse hospitals.

People in Washington today have looked at those three attempts and concluded that things are just moving too slowly. They see these increases in costs occurring, and they say "We must put a stop to them now if we hope to have national health insurance." The word in Washington now is that if costs are not controlled each day $50 million dollars will be spent in health. Something must be done. It is straining all other programs. We will have to make improvements in long term care, in transportation in our cities, and other areas. To do so we must slow the frightening growth in health expenditures. Those are the origins and the major emphasis on cost containment.

There have been three major legislative initiatives which do get into the area of ambulatory care and illustrate Congress' intention to move away from institutional care and move more to ambulatory settings.

They are the Health Maintenance Organization Act; the Health Manpower Legislation which, while it isn't new, really changes the emphasis toward primary care, and therefore, it seems to me it really was thinking about ambulatory care, and the Health Planning Legislation which in its priorities emphasizes ambulatory care. These three legislative initiatives have come out of the authorizing committees. But, what has happened to them through the appropriation process?

The budget for HMO's, if anything, has gone down in the last three or four years. We are now talking about a budget of around $15 million to $18 million. It has decreased since the authorizing legislation.

The health manpower budget peaked in 1971. It has been reduced, although there has been a shift of institutional support to support of residency and other programs that get at the geographic distribution of specialties. It hasn't increased in terms of absolute dollars. For the health planning legislation with all the new HSA's, the budget will be about $125 million which really reflects no growth in expenditures.

The uncontrolled growth in Medicare and Medicaid has left very few dollars for other new health initiatives. It is an overall pressure that I am talking about. The whole budget is just a disagreement among members of Congress on whether these ideas are good ideas and whether we should be funding them.

As we think about the issues of ambulatory care and whether or not these initiatives will be successful, it's interesting to see how they are always reinforced by the financing programs and particularly how Federal Financing Programs, Medicare and Medicaid, may or may not reinforce them.

Consider the expansionary period with the government's attempt with Hill-Burton and manpower legislation to expand the supply of doctors (which I think has been extremely successful), the supply of beds, and encourage new technologies. The reimbursement system was there and apparently effective.

It is really very unclear to me whether or not the reimbursement system can really meet these needs as we think of restructuring the system and some of the problems that have been mentioned. It is really quite different when you are talking about changing the structure of the delivery system or changing the incentives. This requires a fine tuning of the reimbursement mechanisms, something that an awful lot of people who run Medicare and Medicaid and set policies haven't really agreed with or thought about.

So there is an issue of whether or not reimbursement can reinforce those legislative initiatives and legislative policies. Whether they will or whether they can, must come out of Congress.

Let me give you a few examples of some of the problems we have already had. For the last five or six years the Government has been supporting the development of nurse practitioners and physician extenders. But Medicare has refused to pay for them. Medicaid is not controlled in the Federal Government.

Again, there was obviously some disagreement that resulted in fully supporting and training them and not paying for their services. It reflects a difference of opinion about what they should be doing and how they should be utilized in the systems. Similarly, with HMO's there has been a tremendous problem getting reimbursement and policies out of Medicare. It has been very reluctant to pay on a flat rate basis. It still wants to use the usual cost reimbursement mechanism.

A great deal is said about changing the distribution of physicians toward more primary care. We are now going to regulate the residency programs and how many physicians should go into primary care versus non-primary care or hospital-based specialties. But, it is not clear at all that what is important is the reimbursement system. Is it all going to reinforce that?

Will the Federal financing system be flexible enough to support these new initiatives?

In viewing the three pieces of legislation I have highlighted, HMO, the Planning Act and the PSRO's, it is clear to me that because of the problems on the Hill there is no assurance that these goals are going to be met. There just isn't enough cohesion on the Hill to support a legislative policy. There is no assurance that simply because the legislative committee sets the initiatives that it is going to happen. There are too many other hurdles, the annual budget prosthesis, and as I say, changes in Ways and Means and Senate Finance with regard to reimbursement. But I do see the Hill moving toward a strategy which is moving away from the institutionalization and moving toward more emphasis, at least in its new program, toward reinforcing or emphasizing the ambulatory side of the primary care side.

I think the Carter Budget reflects the same sort of groping, the same sort of movement, an attempt to get at the ambulatory and increase ambulatory and deemphasize institutional care. For example, the new cost containment bill that was just introduced this week only includes inpatient services. It does exclude the outpatient revenues of hospitals. It leaves out those hospitals which primarily serve HMO's. It is trying to encourage in some way HMO development with regard to capital controls which is the second part of the bill.

The cost containment bill, as you all know, I am sure, has two provisions. One is hospital reimbursement and one is control of new capital by the Federal government. The bill is going to try to set a limit on capital expansion. I think the numbers we are talking about are something like two and a half billion dollars which is a substantial decrease. But again, it is only looking at acute, short-term hospitals. The bill does not control physicians' offices and does not control clinics. Clearly, it is not trying to get total control of the system. In fact, we may see what Peter Pahling said, "debungling" of hospital services.

The Child Health Assessment bill which has just been introduced also attempts to improve the EPSDT program, the early pre-op screen diagnostic and testing. There isn't an awful lot in that proposal except fiscal relief now. What it does do, which is sort of a sleeper, is encourage care being delivered through comprehensive centers. I suspect that in the next few years we are going to see more of an emphasis in delivery of primary care through comprehensive centers. Although the Administration is only talking about a $25 million increase out of roughly $200 million increase in this program going to these centers, it seems to me that the legislative committees on the Hill are thinking about considerably more money.

If you want to have comprehensive care for children, maybe we should be putting a lot of that $200

million into the expansion centers. We may see, with the new administration, a new emphasis on centers as delivering primary care and ambulatory care. Organized systems will be encouraged.

The third bill is the reimbursement for physician extenders in rural or underserved areas. Again, this is an attempt not only to have physician extenders operate in hospitals, but also, given the potential to operate in physicians' offices or in clinics outside of the hospital. So again, there is an intention to encourage ambulatory care. I guess the question I have been asking is: Is there an ambulatory care strategy? Well if there is, it is certainly dominated by concern over hospital expenditures.

Ambulatory care is viewed as an alternative. But, the question remains: Is it a good idea? I don't think many people have thought a great deal about it, but they certainly don't like the amount of institutionalization and cost increases that are occurring today.

Certainly, there is no ambulatory care strategy in Washington. Every once in a while you hear a bureaucrat or sombody out in the agency ask questions like: "Who should provide care? What types of manpower? Should it be physician extenders? Should it be physicians? Should it be nurse practitioners?" Other people than ask: "Where should it be provided? Should it be provided in outpatient facilities of hospitals? Should it be provided in comprehensive centers?"

Again, there are not many people asking those questions, and there is certainly not much discussion on them. Then the final question: How it should be paid for? Some people are asking these questions, and they are fundamental to the development of any ambulatory strategy. But there is very little discussion on the entire topic.

What we are seeing basically is an attempt to control hospital expenditures, and as a result of that some spill-over and encouragement of ambulatory care without any real thought of a strategy.

Will one develop, is the next question, and I guess that is part of the topic of this session. And if so, how?

Well, it may develop over the next year as people in Washington seriously start to think about national health insurance. I think the attempt will be a very broad one. I don't think you will find an abrupt, all-of-a-sudden, one-time increase in a national health insurance proposal which would by fully implemented in two years. We will most likely see a phasing-in policy. The least they may be asked is what should be the role of ambulatory care? Where should we provide ambulatory care? How should we pay for it?

Also, it could happen just as a result of a very tough institutional strategy now evolving in Washington. Let me describe the scenario, the scene as it works in Washington.

Both congress and the executive branch clearly legislates its reaction to problems. That is, in Washington, you look for a problem and then you legislate around it.

So the first principle is that a problem exists. When a problem arises in the ambulatory care area, if strong institutional strategy prevails, there is going to be an awful lot of discussion about four beds per thousand as a goal, and not much discussion of ambulatory care *per se.* There is a great deal of concern about overbuilding.in this country. And, the amount of capital that we are going to allow for expansion of institutions is also a major issue. Putting very tough constraints on institutions will have some non-spill-over into the ambulatory settings, simply because the hospital sector is this big balloon. If you punch it in the hospital, it is going to come out somewhere else.

There are underlying economic problems driving the system. Some talk about demand and people being not very price conscious; as we have heard before insurance companies are thinking. The Blues are thinking about getting into the ambulatory area. They would like to reduce the price. Still, they are going to find the same lack of price consciousness on the ambulatory side as there is on the inpatient side.

We now have approximately 375,000 physicians. We may have 600,000 in 15 years. That is an increase of 60% in 15 years. They are going to create pressure. If they can't get into a hospital, where are they going to deliver their care? They are going to want to deliver it somewhere, perhaps in group practices or ambulatory care settings.

Physicians are being trained in more and more technology which is becoming portable. They are able to use it for testing and use it outside the hospital. What we may see as we really start to control institutions and start to control other institutional costs, is non-institutional costs or ambulatory costs growing faster over the next few years.

If that starts to happen, given my first principle that Washington reacts to problems, the problem being the

growth in the Federal Budget, we are right back in the pinch.

There is a need for planning. There are problems in involving the community and providers, but I think the way Washington operates in attacking problems, demands that these groups become involved. Washington operates on the basis of consensus. Legislation in Washington doesn't get passed overnight. Congressmen worry a great deal about what legislation they are passing. They know all the time they stand for reelection every two years, and they are very concerned about that legislation and what people say in their constituencies.

It is a problem for all of us. You cannot look to Washington and say, "Come up with a strategy", because Washington will reflect the feelings of a lot of other people, not just the people sitting in Washington. It is a problem for all providers to think about.

Thank you.

Organizing for Ambulatory Care

MR. EVERETT JOHNSON

CHAIRMAN GUSTAFSON: The next speaker for this morning's session, I don't believe, needs much of an introduction to this group. He is the President of the Dunes Group out of Chesterton, Indiana, and has been associated with the faculty here at the University of Chicago.

It is a great pleasure to introduce Ev Johnson.

MR. EVERETT A. JOHNSON: While ambulatory medical care may seem to be a new concern for American hospital administrators, it is one of the oldest forms of health care. Many of the older, or perhaps the oldest of the Chicago Alumni, will easily remember that one of the first field trips they took as graduate students, was to the Central Free Dispensary of Presbyterian Hospital. It was as depressing an experience as visiting the back wards of an insane asylum.

For the next two decades after that experience, the course graduates were busy trying to build, expand and absorb the institutional changes created by a rapidly expanding medical technology and specialization. In the process, hospital costs blew up to proportions that none of us ever anticipated. Along the way, we learned that ambulatory care, except for university hospitals, was something that belonged within the exclusive domain of the private arena of the medical staff membership, or for the Kaiser-Permanente group.

In the late 1960's, when rapid cost increases occurred along with a substantial reduction in primary care physicians and the division of a patient's complex medical problem among a host of physician specialists, many observers and participants of the medical care system wondered anew about the possibilities of redeveloping ambulatory care programs, but in a more modern way.

In the past ten years, a variety of approaches have been worked out. Medical centers have tried to straighten out the chaos in their outpatient clinics, the Federal Government has accepted the belief that ambulatory care is the cost containment wave of the future, and general hospitals have initiated ambulatory care programs to cope with medical problems of patients which overlap several areas of medical specialization and to find answers to imposed caps on revenues and expenses.

CONCEPTS OF AMBULATORY CARE

When a hospital administrator begins to organize his thoughts about ambulatory care, he probably starts by wondering what the difference might be from the medical care occurring in a physician's private office. As he quietly probes members of the medical staff as to what does go on; or during an office visit for his hemorrhoids, he may carefully observe just how the place operates. Soon he begins to see new potentials for rearranging the delivery of ambulatory medical care services. He learns that the medical diagnostic and treatment equipment available in a physician's office is in reality quite limited and emphasizes the man's special interests in medicine. He finds an office with a full supply of syringes, some drugs, and examining rooms perhaps with some special equipment. In a physician's group there would probably also be a centralized medical records room, a laboratory, pharmacy and x-ray. And in a large group, a cystoscopy and outpatient operating room.

In talking with staff members he finds that they are interested in outpatient clinics in order to separate the trauma from medical indigent cases that are flooding the emergency room. He also learns that some of the specialists are interested in either starting their own ambulatory programs such as a neurological diagnostic center because of income potentials or having the hospital set up a program to provide expensive equipment and technician assistance because they want to avoid the necessary investment and risk involved.

As he gets into the "heart of the matter", he figures out that the differences between the old and the new concept of ambulatory care is the proposed scope of service, sponsorship of the program, and in the case of HMO's the financing mechanism. In the past, potentially profitable ambulatory care programs were solely the property of physicians and woe to the hospital administrator who began to talk as if the hospital were more than an economic non-entity. The

development of the HMO's generally legitimized the sponsorship of medical care by non-physician entities, except that a hospital is still exposed to direct pressures of a medical staff if they don't agree with the idea.

As the inquiring chief executive officer reaches some conclusions about ambulatory care, he realizes he has two major questions to decide if the hospital is to sponsor some type of ambulatory care. One is that of location, either on the hospital grounds or at some distant location. The other basic question is the role and mission of an ambulatory program. Should it be developed so as to provide primary medical care, or should it be focused as specialty clinics serving needs not met by private practicing physicians when several different specialities are needed to diagnose and treat a particular medical problem, such as pain, diabetes, sickle cell, headaches, or a back clinic?

Typically these clinics are a response to a general acceptance that a serious unmet need exists that cannot be met totally in a physician's office. The use of ambulatory surgery centers, however, was a response to an economic opportunity to provide surgery at a lower direct cost to patients by eliminating overhead and a battery of routine tests for inpatient admissions.

Costs of Ambulatory Care

When hospital literature is reviewed for studies that clearly establish ambulatory care programs cost advantages, none are to be found. There are many studies and *a priori* statements reported that demonstrate through the elimination of the routine daily service charge a cost reduction is possible when ambulatory visits replace inpatient care.

As is usually the case, it all depends on how costs are counted. In the September 1976 issue of *Inquiry,* Richard A. Einicki reports a cost analysis where substituting outpatient care is a more expensive affair than inpatient care if more than four outpatient visits are required, mainly because of lost wages and travel expense. For one visit, the cost is estimated at 25% lower than the first inpatient day. In general he concludes that cost savings from substituting out- for inpatient care are minimal at best.

When a study is made of ambulatory surgical centers, the cost difference between a free standing center and a program located in a hospital are found to occur because hospitals use average costs in their accounting distribution, rather than marginal costs; also the routine screening procedures required in a hospital facility raise total costs.

If cost reduction is the rationale for increasing ambulatory care programs, it is a will-of-the-wisp hope. If continuity of care, preventive medicine, patient convenience, and access are the goals, then ambulatory care is a useful concept, and will probably increase both the total amount of health care rendered, its quality and the total health care bill.

Restraints

There are several potential organizational restraints operating in hospitals which affect ambulatory care programs. Their particular force and pervasiveness vary by individual institutional circumstances. All such programs will typically be seen by physicians as an economic venture that may possibly threaten their practice financially. Most physicians become concerned whenever additional providers arrive in their marketplace, even though they always talk about being over-worked, and having more patients to care for than they can possibly handle.

In a similar vein, many communities have experienced overt as well as subversive physician activities when a new ambulatory service is planned by non-medicine groups outside of a hospital. If medical staff appointments are needed by physicians in free standing clinics difficulty often arises in obtaining medical staff membership. Fifteen years ago, membership in the local medical society was often a prerequisite for any type of medical practice in a community. Today, lack of this membership is no longer a bar to practice in the community or a hospital appointment.

A classical point of view in a medical staff dominated by private practice physicians is that salary arrangements will inhibit physician productivity, while fee-for-service reimbursement encourages maximum effort. This may be so, but only in circumstances where diagnosis and treatment procedures are straightforward, the fee for structure already defined, and complex unusual diagnostic and therapeutic procedures avoided.

For ambulatory care programs this means that readily identifiable procedures which are not complex and have standard fees already established, and do not involve several physician specialists, will fit the fee-for-service model; such as primary care programs and surgical centers. In complex diagnostic areas, such as headache or pain clinics where several specialists may be required for one patient with their participation not clearly identifiable to him, salary arrangements are more useful.

Even when a fee-for-service arrangement is proposed, there are many hospital situations where physicians will balk at initiating an ambulatory care program because of a hospital's sponsorship. Somehow they believe it is unethical for a hospital to invade their land of opportunity even though time after time they have not reached out to fill a medical service gap. Too often their response is that all people in the service area are receiving needed medical care. Ignored is patient convenience, continuity of care, and the fact that community studies conclusively demonstrate unmet medical need and demand.

Organization

The key to success in an ambulatory care program is to have an adequate number of physicians available who are providing quality service. In inner city areas, the attractiveness of traditional forms of medical practice to new primary care physicians has steadily diminished. And as a result, the number of primary care physicians has declined. Until new elements of attractiveness are provided, this trend will not be reversed. The establishment of an ambulatory care program adds nothing to this situation unless the program appeals to young graduates in medicine.

Realism is essential in developing a program to attract new physicians to a community. There are at least two ways an ambulatory care program can appeal to physicians. The first is that the program provides an opportunity for physicians to develop a specific panel of patients. This means that the physician retains the right to either accept or reject patients from his panel. Since some physicians do not desire to treat certain types of illness, they eventually will leave a practice if forced to provide care in which they are not interested. By providing a staff physician with the right of acceptance, he can identify more closely with "his" patients and will have an increased concern for their well being.

The second way is that ambulatory care physicians should have an opportunity to practice on a fee-for-service basis where possible. To encourage new physicians to settle in a community and to provide incentives for above average productivity a guaranteed limited amount coupled with fee-for-service concept is desirable. This arrangement places a floor under their income, but does not restrict their total earnings if they exceed the budgeted number of visits for the guarantee. Because incomes of established physicians in totally private practices are frequently significantly higher than in ambulatory care programs, physicians recruited may leave after a short tenure if they can not approach income levels that are available through an independent practice.

Direction and supervision of physicians in an ambulatory care program, when sponsored by a non-physician owned entity, is often a sensitive issue and should be handled by a medical director. Physician appointments in an ambulatory care program, whether full or part-time, or consulting should be recommended by a medical director, approved by a majority of the full-time physicians, and appointed by the governing body.

All appointments, both full and part-time, should be made by a written contract in which specific authority, responsibility and accountability are defined. A desirable contract should include:

1. The physician's responsibility for maintaining a practice schedule that has been determined by the medical director.
2. Participation in limited weekend, evening and on-call service as determined by the medical director.
3. The maintenance of a medical staff appointment at a local hospital.
4. The responsibility for providing competent medical care to patients on his service.
5. Participation in the work of physician committees of the ambulatory care program as assigned.
6. A grant of power of attorney to the ambulatory care program for billing and collection of patient fees.
7. Responsibility for visiting hospitalized patients daily, or as frequently as desirable, from his service.
8. Recognition of the authority of the ambulatory care program for establishing a physician's fee structure.
9. Referral of patients to the consulting staff of the ambulatory program when additional specialized medical care is required.

The contractual responsibilities of the ambulatory care program should include:

1. A definition of the method of payment and productivity level required.
2. Provision for an annual contract which may be ammended with 90 days notice after the first year.

3. Provision of the same fringe benefits as other employers of the program.
4. Payment for malpractice insurance at the customary current limits of liability.
5. Authorization for the purchase of additional fringe benefits through a reduction in the minimum income guarantee of a compensating amount at the direction of the physician.
6. The payment of professional and staff dues.
7. Provision annually for four weeks vacation.
8. Provision of two weeks of professional leave annually, with expenses paid by the program for approved educational activities.
9. Annual review of the physician's medical and administrative performance, and providing him with a written evaluation.
10. Authorization of the physician to accept or reject patients assigned to his service.

The contract provisions outlined apply to both a primary care program and to specialty clinics.

Organization of the Program

In the past, delivery of ambulatory care services has been primarily one of loosely organized programs geared to the convenience of physicians and program staff. A major job of ambulatory care must be towards implementation of an organizational structure consistent with health care delivery patterns acceptable to community expectations, which is personalized care.

A key element to accomplishing this goal is the scheduling system used by the program. Traditionally, a block appointment system has been used, where several patients are given appointments at the same time, usually at the beginning of the morning or afternoon hours. This type of scheduling system unduly penalizes the patient who must wait an inordinate period of time to see a physician and also creates periods of lower productivity for physicians and program staff during the late morning and afternoon hours.

A preferred method of scheduling for patient convenience is an appointment system. Generally, about 80% of patient appointments are kept and can be adjusted as operating experience determines a specific rate for the program.

Another characteristic for an ambulatory care program should be the development of teams directed by physicians and supported by other personnel. Organizationally, an ambulatory care program should stand as an independently functioning unit within the hospital. Its medical director should be the chief executive officer of the program and responsible for developing policies and procedures within the scope of authority of his position as established by the hospital administration.

The program director should be the chief executive officer responsible for daily operations. His duties should include developing and maintaining the following functions:

1. Job description
2. Wage and salary control
3. Position control
4. Procedure manuals
5. Personnel policies, consistent with hospital policy
6. Credit and billing procedures within the overall hospital financial system
7. Marketing activities
8. Short-term planning—annual
9. Inventory control

The operations of an ambulatory program should be grouped into three functional areas: nursing staff, business function, and professional staff.

Each area should be directed by a working supervisor. For example, the nursing staff should be directed by a designated chief nurse, who in addition to her clinical responsibilities, will also provide the necessary decision-making to keep the nursing staff functioning efficiently and effectively.

The other two areas should also have persons appointed to provide the necessary coordination and decision-making needed for their activities.

The typical physician's office employs two ancillary personnel per physician. Guidelines for an integrated urban health strategy issued in December 1976 by the Health Services Administration of the Department of Health, Education and Welfare call for a three to one ratio as a ceiling in primary health care delivery systems, which is also typical for organized group practices. However, these ratios only have significance if the progress is defined. A primary care program needs to be more than competition for a private practicing physician's office if it is to meet the needs of the public in a modern way.

Medical care delivery is a system with many components and functions. A major problem today with its traditional form or organization is that a patient in need of a variety of diagnostic procedures, tests and consulations, must drive all over town to

obtain the necessary service often during several different days. It is an inconvenient, time-wasting experience.

An organized ambulatory care program should make one stop medical care a reality. This means that two to one or three to one ratios are meaningless. For example, a comprehensive primary care program should include functions for an organized approach to patient reception and scheduling, medical records system, billing and secretarial services in its business office. Its professional services other than physicians ought to include health education, pharmacy, laboratory, x-ray, electro-diagnostics and social service. The nursing staff should use both registered nurses and nurse practitioners grouped into teams with the physician staff.

My experience has shown that the use of a nurse practitioner can expand the productivity of a physician by about two-thirds. The 1975-76 *AMA Profile of American Medicine* reported the number of visits, per week, to general practitioners as 186.3. By the use of nurse practitioners, this capacity could be expanded to 310 visits per week, the available hours of service lengthened, and the unit cost of providing diagnostic and treatment capability significantly reduced.

In addition to the three divisions of the program, other arrangements are needed for comprehensive care. Formal referrals should be made through an organized system for dental, optometry, and podiatry services when required. Even though these practitioners are on an independent, but affiliated basis, it is desirable to have them located in the same building. At a later stage of development, consideration may be given to incorporating these services into the ambulatory care program.

Since other medical care specialists beyond the primary care physicians will be needed to provide additional diagnosis, treatment and hospital services a referral panel should be established. Laboratory services for complete blood counts, blood sugars, pregnancy testing and urinalysis should be available at the primary care program as well as any other laboratory test that has a high volume and low capital cost. Arrangements should be made for an electrocardiogram and pulmonary function studies. A referral capacity should also be developed for indigent patients to determine government support and provide medical care payments. Other arrangements are needed for mental health, drug addiction, and alcoholism treatment.

Location of an ambulatory care program is another important factor. A usual rule of thumb is that the patient will travel 20 minutes or three miles for primary medical care.

There should be easy parking and public transportation to the location.

Marketing Program

Simply establishing an ambulatory program, even under conditions of significant medical demand, will not generate patients. The public must know that a program has been started, its method of operation, and the services available.

Potential patients must be aware of the program and be persuaded of its merits. The program will need more than "walk in" patients and therefore, must develop an effective program of communications and promotion.

Traditionally, medical services have been circumspect in their promotional activities. However, in the last several years, Health Maintenance Organizations, health insurance carriers, Blue Cross Blue Shield and Planned Parenthood have used promotional techniques to make the public aware of their products and services.

A properly planned program to promote an ambulatory care program is in fact a positive opportunity rather than a necessary evil. For effective promotion, the ambulatory care program must use an integrated communications concept.

The developmental planning for an effective marketing program requires specialized communication knowledge and skills to reach the target population. This kind of marketing involves:

1. Who should be the spokesman?
2. What meanings and concepts should be conveyed?
3. What communicating channels are most effective in delivering specific meanings to the target population?
4. Which parts of the target population receive specific information?

A specific program must identify for the public their need for medical care and how the services of the program can efficiently and effectively satisfy their needs. Many media and communicating problems

must be solved in the specific context of community characteristics to be able to develop an effective marketing mix to promote an ambulatory care program. Because the operating expenses of a new medical venture are high, and can only be offset by quickly developing a patient clientele, it is important that prior to its opening, a well planned promotional program will have generated a willingness to try their medical services.

A parallel requirement to a marketing effort is a satisfactory initial operation of the ambulatory care program. Patients must be promptly scheduled and seen, staff personnel must be pleasant, concerned, and the facilities must be attractive.

In essence, an ambulatory care program is entering into a competitive market situation, even though there is a potential unmet medical demand, and must be a desirable place for receiving medical services that are recognized for their quality and convenience.

Conclusion

Most of the ideas discussed have been focused on the characteristics of a general medical care ambulatory program. This kind of program is more comprehensive than the usual type of specialty clinic a hospital develops within the institution, and therefore is more useful to highlight some of the issues.

A hospital clinic may be anything from a designated time to see a particular kind of patient in the emergency room, such as a venereal disease clinic, to an elaborate fifty or sixty clinic operation with its own facilities.

In selecting a general type of ambulatory care program to discuss, I have assumed that this is an area of greatest interest for most general hospitals. It is a response to the substantial decreases in the number of primary care physicians on their medical staff, and particularly general practitioners. The greatest unmet demand for medical care is probably at this point. Of course, one of the corollary programs rapidly being developed by hospitals are family practitioner residencies in the anticipation that their graduates will remain in the community. The issues about ambulatory surgical centers have not been discussed because this has been familiar to hospital administrators for a number of years.

Probably the major determinant of whether a hospital moves in a substantial way into ambulatory care programs will be its medical staff. Even though this program has the potential of providing quality, comprehensive care in a new way in the community it will probably only be supported by physician specialists who anticipate it as a referral souce. The other members of the medical staff, in general practice, internal medicine, pediatrics, and obstetrics will examine such a proposal carefully, discuss it in clinical terms and quietly take a position in economic terms.

Ambulatory care will probably arrive on the hospital scene in a big way in the next decade, but there is sure to be a lot of administrators rotated to new positions in the process. Despite this hazard, which will affect only a small portion of health careers, the drive for organized ambulatory care programs will be a major force in medical care in the years ahead.

DISCUSSION

with Stephen Loebs, Stanley Wallack and Everett Johnson

Chairman Gustafson: We are ready for any questions that any one would have of any of the speakers.

Question: Professor Loebs, you outlined the three major problems as a marketing problem, a leadership problem and a financial problem.

One could take the position that if there is a marketing problem, there is no leadership problem and no financial problem.

Mr. Loebs: What Ev Johnson was saying supported the observations that I made about the importance of marketing that product. If the hospital or any other ambulatory program is not able to market a product that is going to be resonably competitive with the alternatives, it's not going to succeed.

What Ev Johnson did not mention, but I think it's an underlying important factor, is that without the financial underpinning for a program, i.e. reimbursement plans such as third party payors or people who are not willing to pay out on a cash basis, then your marketing efforts and leadership are going to be for nought.

Question: Mr. Johnson, you seem to imply that

one of the major problems for the ambulatory program is marketing.

I was wondering if you think one of the reasons why HMOs haven't truly succeeded is a breakdown in the marketing of their product? And, if so, how could they improve?

MR. JOHNSON: I am not sure that it's inadequacy in marketing. It may just be the fundamental concept that caused them problems. Plus, if they are required to be a Federally certified HMO, there is another set of requirements that inhibit its growth.

HMOs have always been very interesting because for years physicians couldn't advertise, and then all of a sudden we get a new wave, and it's legitimate for everybody to advertise. The halls of purity all of a sudden began to take on the same aspect as any other marketing organization.

My reaction is, "Hurrah, they broke the gate open for us." I see no objection to it.

The use of marketing is not all that clear-cut right now. One must be careful and selective in using it. You don't want a crazy adman going in there right off the bat. But I drive down the road once in a while, and there is a sign that says something like: "Have you had an abortion lately?" Ten years ago you would never see a sign like that. So, the gates are open for us.

MR. LOEBS: I would agree. I don't think it's a marketing problem per se that has limited the growth of HMOs. I think there are other problems that might be subsumed under marketing.

One of the problems that some of the HMOs are having is recruiting physicians. Another problem, interestingly enough, is that in some areas HMOs have such an unexpected large enrollment, that they have had to cut off new enrollees until they are able to catch their breath and expand. The whole process of expanding to meet additional population groups is a particularly difficult one for an HMO which has to forecast revenues with extraordinary care. My impression, from talking to some HMO administrators across the country, is that they are very hesitant to expand their potential enrollment because of a fear of a loss and uncertainties in the marketplace right now, which may be sifted out in the next year or two as the HMO Act itself becomes stabilized. So it is conceivable in the next two or three years that we will have growth of HMOs as the legislative environment becomes somewhat more stabilized.

QUESTION: First, I would like to congratulate Ev Johnson on presenting an outstanding paper. I think he did a great job and made a lot of fine points. There are two points he made I would like to hear discussed a little more. You said you don't see ambulatory care as being the solution to health care costs and used the term the "will-of-the wisp". I would like to have you re-emphasize that. I think our Congressional representative, Mr. Wallack, didn't hear that. I want to be sure he does and that he takes it back to Washington.

Secondly, at the very end you really hit on the big problem. That is, the typical American community and the typical American hospital has private practicing physicians who fight this kind of a change, even though it is a badly needed change.

MR. JOHNSON: I have looked at some of this literature, and I think there is a great deal written that is just "pie-in-the-sky" kind of thinking. The ambulatory surgical center is a good example of this. Their costs aren't any cheaper than a hospital's except that a hospital under Medicare has to average cost for its overhead departments into the revenue producers, and this raises their total cost. If they were allowed to marginally price and cost, they could then be competitive with an ambulatory care center. It's a question of how you count costs. That is all it is.

If the patient's time has no value, that's different. But, when he has to hire a babysitter for his kids to drive his wife 50 miles, there is a cost. Too often in these studies they simply don't include those kind of costs. Yet, if you look at the total cost to society rather than to compartmentalize it, you begin to see that it's not all that great a savings. Furthermore, the more you spread it out, the more illness you are going to find. And every time a doctor finds a disease, he treats. Consequently, the total health bill could go up even more.

In terms of private practice, what I outlined was a strategy that I think is acceptable to more people than the HMO route or the closed panel group practice or however you want to phrase it. I don't see that you ought to tilt any more windmills in this thing than you have to. I think that administrators are going to be caught in a vise if they try. Their census may start to go down. If the doc who is admitting patients can see some light at the end of that line outside his office, he is

worried. He wants to see that line go clear out to infinity, and anything short of that worries him. So he is going to be a very vocal opponent of the administrator doing anything that could shorten that line.

It could be that we are going to see the development of for-profit chains. Clearly this is speculation, but you could do it just like any of the investment hospital chains did except you move into the primary medical care market simply because the hospital is locked out of it due to a power struggle between the medical staff and hospital administrator.

MR. WALLACK: When you look at studies that have looked at the effect of increasing insurance for ambulatory care, total expenditures rise. That is because you are doing two things. You are not only bringing more people into the system, which may be a good thing, but you are also bringing some people who are inpatients to an outpatient basis. Many could have been treated as outpatients before but weren't because of financial constraints. The difference may be who was paying, and who wasn't, or the amount of money they were paying.

Restricting hospital admissions, as the legislation is aimed at, will take people out of the hospital and get them treated on an outpatient basis. If you only do that, it may be less expensive.

I would mention the diagnostic testing and technology, non-invasive technologies and the growth of physicians, as areas which may be forced outside the hospital by the kinds of regulations now being placed on the institutions. Therefore, it is going to be much harder to control the system. There will be 500,000 or 600,000 practicing physicians and about 6,000 or 7,000 hospitals. So I can agree that we may be spending an awful lot more by the way we are moving now.

MR. LOEBS: The only way that total costs to the community are going to be contained or perhaps even reduced under the possibility of increasing total costs by ambulatory care, is to close down some of the existing facilities that are currently being used. That is, the only way you are going to save cost is by closing some hospitals. Otherwise, you will see escalating total costs for medical care with more organized ambulatory services.

So I think Ev Johnson is right. The hope for any cost containment is will-of-the-wisp. In fact, we are going to see the reverse, and the evidence backs that up. What are the possibilities of cost containment within expanding, organized ambulatory care programs? I would submit that if you are not going to shut down any current facilities, there is no hope at all.

MR. WALLACK: It really depends on what you are going to do with paying the bill. Obviously, we wouldn't be spending anything on hospital costs if the price to people who are paying the bill were nearly what the cost is. It's really a factor of insurance and insurance coverage.

One way certainly to cut back cost and to end all this discussion is to make patients pay a higher percentage of the bill. I don't think that is politically viable in the hospital sector, but the question is going to be raised certainly with regard to ambulatory care. That is the way it could be. We will never stop increasing costs until you make people pay some share of it.

QUESTION: Mr. Wallack, the element of your talk that left the impression that the new cost control programs wouldn't adversely effect ambulatory care somewhat bothers me. It bothers me that you believe that. I can argue strenuously that the best way to kill ambulatory care is to cost control or reimbursement control the hospitals.

What we need to do in ambulatory care, at least in the hospital-based ambulatory care programs that I am familiar with, is to recover maybe half the expense of providing a service. Maybe half of what we don't recover is buried in the hosptial cost structure and the other half is covered by in-patient surpluses and a direct subsidy to outpatient. Any move to squeeze the inpatient side of the hospital, the marginal effect or the leverage effect, will really be felt very strenuously on the outpatient side. And, unless the Government is prepared to pump huge quantities of money into outpatient as it squeezes inpatient, the short run effect will be a serious crippling of many of the current programs.

MR. JOHNSON: I think one of the things we ought to do is quit calling them cost caps and call them revenue caps.

QUESTION: Mr. Wallack, you mentioned two strategies that are occurring at the Federal level.

What about the strategy of converting existing hospital capacity to ambulatory care? Is that strategy being discussed and viewed?

MR. WALLACK: I don't think it really is. To the extent that there is an ambulatory care strategy, it has all evolved from some hope that it may be cheaper.

The efforts of the policy people have really concentrated only on the first issue, getting at revenue caps and getting at the growth of insitutions. I don't think an awful lot of thought has gone into where one might want to emphasize ambulatory care. There has, of course, been the Talmadge amendment. There is some money in there, a small sum of money to convert facilities, and there as been some discussion of that, but not a lot.

QUESTION: If I understand correctly, the panel said that ambulatory care is going to be more expensive.

The question is what incentive is there to use ambulatory care if it is going to be more expensive?

MR. JOHNSON: I don't know.

CHAIRMAN GUSTAFSON: Is there any other reaction from the panel?

I guess you are going to have to wait for tomorrow morning to get that one.

QUESTION: The answer to that question is that it may be less expensive than inpatient care. It may be.

Even with all of the additional costs it still would be less expensive in my estimation than inpatient care.

MR. JOHNSON: The scenario I see developing is that you get an ambulatory care program going and pretty soon the docs are no different there than they are in a hospital. Pretty soon some wise guy says, "Gee, we are going to need new screening procedures." So, after a few years we are back in the soup again of having 25 or 30 screenings for a patient going into the program on the logic that this one stop is the only chance you are going to get to help that poor guy for the next year so we had better check out the whole system.

That is the way it runs in the hospital all the time. I don't see why it will be any different over the long haul.

QUESTION: I would like to identify myself to give sort of an idea of my orientation presently.

I work for the State of New Jersey Health Department and am responsible for the development of ambulatory care in general. My unit is called Alternative Health Systems. Let that serve as a background to what I am saying.

What I am hearing here basically is that if we push the inpatient bubble this way, the outpatient bubble is going to come out this way.

If we take the present anomalies and inefficiencies of the inpatient system and push them out this way, we are going to get outpatient inefficiencies and anomalies. Perhaps we should look beyond that and start talking a little bit more about going after some of the economies before the big brother does it for us, or attempts to do it for us in utilization control and quality control.

I am dealing directly with things like rate setting and Certificate-of-Need, which tend to inflate in many ways the hospital costs. We have to look for more incentives, positive and negative, and more specific financial incentives for providers to be more serious about appropriate utilization of services and quality of care.

We have to look at a system that is going to put more emphasis on preventive or maintenance care. Of course, that is one of my prejudices because I am the counsel for HMOs in New Jersey. Notwithstanding the gentleman's remarks before, while they are having trouble getting off the ground, the HMOs are, in fact, indicating by a lot of studies that have been done that they are generating interesting economies in both quality and utilization.

MR. LOEBS: An important issue is the existence of a financing mechanism for the ambulatory care alternatives. The HMOs do have that financing mechanism built in. With the premiums, the costs of ambulatory care are covered for the subscribers. In many areas of the country the financing mechanisms just aren't there to pay for the alternatives, i.e. the ambulatory care. If you don't have Blue Cross underwriting ambulatory care costs, if you don't have Medicaid underwriting comprehensive ambulatory care costs, if you don't have other sources of financing underwriting those costs, then I don't see much incentive at all for the providers to be involved in developing the organized programs that Ev Johnson is talking about.

The problem is going to be more acute as time goes on, as the states cut back on their Medicaid programs. If you study what states are doing across the country right now, many of them are cutting back very quickly and very dramatically in the benefits that they are covering. They are cutting back on reimbursement levels, and eligibility. With those cut backs the incentives for providers to be involved in ambulatory care seem to be diminishing.

QUESTION: Before we overlook the entire effect on inpatient care that increased outpatient care will have in the financing area, it is important to bear in mind

that as we seek lower cost alternatives to the care of the sick person, the remaining people in the hospital are going to require increased degrees of cost or increased intensity of care. So that the remaining inpatients are going to be much higher in cost than they are now.

MEMBER: We really haven't stepped back and taken a look at what is primary, what is secondary and what is tertiary care, and where does the hospital fit in this? If we do, and think of health care delivery systems and think of primary care as being primary care, intake and diagnosis, secondary as referral still within the ambulatory care structure and tertiary as being the only part of the care system that is related to hospitals, you can begin to look at the hospital not as the center of the health care delivery system but probably as a spoke on the continuum.

Until we do start thinking in terms of another organizational base from which the leadership and the methods of financing can develop, we are going to be spinning our wheels because we aren't tackling the fundamental issues that are a part of the problem, that is, financing and leadership.

MR. JOHNSON: What I would observe is we have called ourselves hospital administrators. In effect, we are managers of medical care systems.

The problem that we face as hospital administrators is that our organizational structure is not appropriate at the top levels to do the job that needs to be done.

MEMBER: Let's put the money on the people that have the authority to control cost. Let's get it out in the system. Who are the health care deliverers? Let's make them responsible financially as well as professionally. Let us help them do it, and not necessarily try to direct them in doing that.

CHAIRMAN GUSTAFSON: Now we talk about allocating more cost from inpatient into outpatient, and at the same time we talk about wanting to educate more residents and physicians in ambulatory care with limited government money. Is there going to be the funding? With the cost technically allocated to outpatients, can teaching institutions remain competitive with those in private practice? Or are we going to have to assume another model to deliver service?

MR. WALLACK: I don't have the answer, but there is a lot of debate in Washington right now. With Medicare and Medicaid they don't want to pay for education. It is not a part of services. In fact, there has been no policy. There has been no resolution about how the manpower bill is going to be funded in the long run. There is in manpower legislation, as you know, an awful lot of front end money. The reason that was put in there was to pay for primary care that the reimbursement system does not provide today. That is again a band-aid approach to a large extent.

MR. BUGBEE: This is an interesting discussion. I get the feeling that the national policy as presented is that one of the primary objectives of going to ambulatory care is to save money. I guess that is a worthy aim. I believe that several have illuminated the problem.

The thing that interests me is what is going to be done about the number of physicians. I believe that there are estimates that each additional physician leads to expenditures of $200,000 or some such sum. Yet, in spite of the squeeze on hospitals, I hear little of controlling the number of physicians.

I think we have about doubled the ratio of physicians, for instance, that they have in England at the moment and the pipeline is full and hardly spouting yet compared to what it will. It seems to be the control of cost needs to get into that somewhere.

One final point. I was reading a discussion not long ago by a Hospital Administrator trying to figure out how to organize ambulatory care. It ended up that we can't bell the cat. The cat was the physician, and it's awfully hard to "bell" for an organized outpatient if there are going to be a great many out practicing medicine.

MR. WALLACK: The figures you are using may be low on expenditures per physician. There have been very few studies done on the amount of expenditures generated per physician through hospitalization and testing procedures.

One study that is being widely quoted was a study of some interns in North Carolina, in 1973 or 1974 where six out of the seven of them generated $260,000 each, including the total amount they generated in health care, physician billings and hospital billings. That was in 1973 or 1974. You have to inflate that, of course, to 1977 or 1978, so you may be talking about $350,000 per physician. Then if you start to extrapolate that out with this last increase, and those may be a 50% increase in physicians in the next 15 years, you are talking about an awful lot of money.

It is going to be very difficult to cut back on physicians up to a great extent. If you cut back entirely on foreign medical graduates, which some people think the current legislation has done, you may remove about 75,000. If you did it today and you said, "You can't have another foreign medical school graduate in this country," you may reduce the number of M.D.s by 75,000 in the year 1990.

CHAIRMAN GUSTAFSON: I would like to thank the speakers on behalf of all of us. We have enjoyed it.

Some Case Studies in Ambulatory Care

MR. L. RUSH JORDAN

The Chairman for the afternoon session was Selwyn Becker who is Professor of Behavioral Sciences at the Graduate School of Business and a member of the faculty in the Program of Hospital Administration.

CHAIRMAN SELWYN BECKER: Our first speaker is Rush Jordan who is President and Chief Executive Officer of the Ochsner Medical Foundation in New Orleans, Louisiana.

MR. L. RUSH JORDAN: The institutions occupy a 31 acre campus on the east bank of the Mississippi River about 5 miles upstream from New Orleans. The parking lot runs directly up to the levee, and one of the great pastimes of patients, and sometimes employees, is to watch the ships going up and down the Mississippi River.

There is a shell road on top of the levee, used for bicycling, horseback riding and jogging. It is quite a recreational area for the people in the New Orleans area.

The main building houses the Ochsner Clinic. The Ochsner Foundation Hospital is in a new facility. The hospital and clinic are the two largest components of the Ochsner Institutions.

In addition, we have a 270 room hotel that is devoted primarily to the outpatients who come to the clinic. It is a very popular place with a very comfortable bar, health club and a very fine restaurant. The Libby de Four Building is the home of the Foundation Offices. All of our Foundation Offices are located in this 2-story structure which is west of the main building. Research developed at such a pace that we have had to build a very nice building away from the structure to house our clinical research laboratories. This building is known as the Richard W. Freeman Institute.

In May of last year we merged with the operation of the Eye, Ear, Nose and Throat Hospital, a specialty hospital that is located in the University Medical Center area in downtown New Orleans. There are four services there: otolaryngology, opthamology, plastic surgery and oral surgery.

We have a $65 million expansion program which will be completed in approximately six months. The program entails essentially the addition of five floors to the clinic, four floors on the hospital, 100 rooms to the hotel, a major parking deck for 1470 cars, and a materials management building for the handling of all areas of work that do not require the presence of the patient, the doctor or the patient's family.

We have approximately 155 senior physicians and some 31 specialties at last count. An expansion program of the medical staff is in progress, having brought on some 30 physicians in the last six months. A major purpose of our Foundation is education. We have 160 interns and residents in graduate medical education in some 23 approved residencies.

We have medical students from the two local medical schools, Tulane and Louisiana State University, and maintain a school for allied health sciences in which we have seven different programs for paramedical personnel.

In medical research, our major areas are hypertension, oncology, cardiovascular diseases and work in artificial tendons.

The Foundation Hospital originally was opened in 1954, and the present construction program will include a major renovation. When completed we will have not only new construction, but all the old construction will be completely modernized, with new wiring, plumbing, lighting, ceilings and painting.

That gives you a little impression of what we are today and some of our development over the years. But, I want to go back to 1940 when the Tulane University Medical School was already 105 years old and was widely recognized as one of the outstanding medical schools in America. It was located across the street from the huge Charity Hospital of Louisiana in New Orleans which had been established in 1937. Dr. Alton Ochsner at the time was professor and chief of surgery at Tulane and one of the world's foremost surgeons, a pioneer in cardiovascular and open heart surgery. One of his disciples later went on to Houston, and you know well the success and reputation of Michael DeBakey. Louisiana State University School

of Medicine was not founded until 1936, but it also was located on the grounds of Charity Hospital in New Orleans and shared its clinical facilities with Tulane.

It was during the period of 1939-1940 that Dr. Ochsner had conversations with other physicians on the medical staff at Tulane about developments in practice patterns elsewhere. He mentioned the relatively new (less than a decade old) clinic at Duke, the old and famous Mayo Clinic, the Lahey Clinic, and the Cleveland Clinic. Dr. Ochsner brought some of these leaders, including Dr. Lahey, to New Orleans to talk to the medical faculty and the University in an effort to interest them in developing a clinic for the private practice of the medical staff.

Dr. Lahey was extremely interested and in his characteristically positive manner offered a tremendous amount of sound advice based on his own experience. You will be interested to know that he suggested to Dr. Ochsner that the administration should be kept small and explained that in his organization he alone made the decisions. He further suggested that we seek a location that would permit greater expansion in the future than we could then envision and advised us to refer our patients to hospitals operated by others and to avoid all of those problems that are associated with running and financing a hospital. An interesting side comment is that the Lahey Clinic is at present in a construction program building their first hospital. Dr. Lahey also recommended that the medical staff that went to the clinic resign their medical school appointments and devote full time to the development of the clinic and the clinic practice.

So after much work and a lot of controversy, the University told Dr. Ochsner, no. Under no circumstances would the University go into private practice competition with the local practitioners.

Dr. Ochsner was able to talk four of his colleagues, all of them surgeons, into pooling their resources and building a group practice in New Orleans that would hopefully follow in the steps of Lahey, Cleveland and Mayo Clinics.

To illustrate the extent of bad feelings this generated, I might add that on the night of Thursday, April 13, 1941, after it had been announced in the paper that they were forming a group practice clinic, each of the founders had delivered to his home a leather pouch containing 30 silver dimes. Thirty pieces of silver "from the physicians and dentists of New Orleans to help you build your clinic."

According to the original agreement among the five founders, each one invested an equal portion of the capital and operating funds and was to receive an equal share of the earnings. By the time they located the building and were ready to open, they had recruited a total of 19 physicians, six employees and one business manager.

Early in their planning the founders had agreed upon the importance of medical writing, and knowing something of the abilities of one of the local medical editors hired her to establish a department of medical communications. The division exists to this day, taking the rough manuscript from the physicians, handling all of the photographs and charts, correcting all of the problems with the grammar, punctuation and spelling and getting it ready to submit for publication.

From the start, the founders insisted that all the patient's appointments were to be arranged through a central appointment office. They moved all of their former patient records to the new building and started a central record room with a unit record system. The clinical and x-ray laboratories and pharmacies were in the same building and all reports were filed in the patients' records. Bookkeeping and accounting were centralized, and the patients received one single statement for all services received.

In the early Forties hospital beds were in dire short supply, something we can't say today. The lack of availability caused a great deal of difficulty to the founders because very shortly after they moved into the clinic building, they were dropped from the medical staffs of every hospital in New Orleans by action of the local physicians. They dropped them from the medical staffs with the exception of the Tuoro Infirmary.

In 1943 the founders considered changing the clinic partnership into an association similar to the Mayo Clinic. They were organized strictly on a partnership basis. However, their attorney informed them that Louisiana law very strictly prohibited the practice of medicine by a not-for-profit corporation or foundation and told them he thought they would run into severe difficulties if they attempted to incorporate in any way and continue to practice medicine after incorporation.

These discussions led in 1944 to a decision to establish the Alton Ochsner Medical Foundation, a

not-for-profit entity. By 1944 the assets of the partnership had significantly increased, and they began to worry about what could happen. Many group practices end up having arguments. There are problems. They split up and the group practice dies. They wanted to insure that, number one, the group practice would continue; and two, continue even after they retired or died.

So following the Henry Ford model and Cleveland Clinic models, they set up the Alton Ochsner Medical Foundation and gave it all of the assets of the partnership, property, equipment, and operating funds.

Thereafter—and continuing to this day—the Ochsner Clinic leased all of their buildings, grounds, furnishings and equipment from the Foundation. The Foundation establishes a fair rate of rental and charges them on a regular monthly basis for all of the equipment and all of the facilities which they utilize. As you know, the Mayo brothers had made a similar move which served to insure the continued success of the Mayo Clinic long after they died. Therefore, the founders believed that this step would perpetuate the group practice of medicine in the Gulf area and would also open the way for the Foundation to receive tax exempt donations from friends and patients.

The first article of the foundation's charter is very interesting, and I would like to share it with you:

"The general purposes of this corporation, the Alton Ochsner Medical Foundation, shall be scientific, educational, literary, and charitable, and to promote medical, surgical and scientific learning, skill, education and research in the broadest sense and to aid and advance the study and investigation of human ailments and injuries and the causes, the prevention, relief and cure thereof without any distinction as to the means of the patient, his race, or his domicile, and to provide more and better care for the patient with no means and those with moderate means and to endeavor to make the care and attention of such patients equal to that given to patients with the most ample means to conduct more research, both clinical and laboratory, and in that connection to establish and operate medical libraries and museums and to provide fellowships for approved young physicians who have had at least one year of acceptable hospital training in order to enable them to continue their studies and research to make available increased teaching personnel for Class A medical schools".

At the founding the Board of Trustees consisted of the five founders, all physicians, and two laymen for public members, an attorney and a man who was very high up in the financial brackets of New Orleans.

The Foundation was successful, and in 1944 the decision was made to install a photographic studio, not only for research purposes, but for patient care. They designated the first director of research, and the efforts of this new director of research were instrumental in getting Dr. and Mrs. Otto Shales to leave the Peter Bent Brigham Hospital in Boston and come to Ochsner to establish basic research in the new institute.

Despite the anxieties of war and the overcrowded schedules in 1944, the trustees still considered the possibility of having their own hospital with the Foundation owning it. They had numerous talks back at this period with Tulane because Tulane had no single place for the faculty to admit their private patients. Hours, days, and weeks passed and our official records are loaded with the minutes of the meetings with Tulane back in the early Forties. The final decision there was that Tulane did not desire to have a hospital just as they did not desire to have a clinic, and they would not participate. Incidentally, six months ago Tulane opened a brand new university clinic and university hospital in the medical center area very close to Charity Hospital and the medical school building.

Although Dr. Lahey and some of the Mayo Clinic administrators had previously advised against ownership and operation of a hospital, the critical shortage of hospital beds in New Orleans forced the founders to explore every possibility because as I stated, they had been dropped from the membership of every community hospital in the city with one exception and that institution was running at about 98 or 99 per cent occupancy. Although the Foundation trustees fully appreciated the community's need for an additional hospital, they really didn't think they could raise the money necessary for the construction. They started extensive talks with Tuoro about the possibility of the foundation raising some money and helping Tuoro build a wing of the hospital which would be devoted to Ochsner patients.

Tulane faculty members became concerned about this and decided because some of them were admitting at Tuoro, they too had better participate in the talks. So it became tripartite, with Tulane, Tuoro and Ochsner in many meetings and many talks. In the final analysis, the medical staff of Tuoro Infirmary voted unanimously—with the exception of the Ochsner vote—not to build a wing for Ochsner and not to have Tulane share a wing with them or with Ochsner. The Tuoro expansion possibility fell by the wayside.

As early as 1945 the need for housing out-of-town patients near the clinic was recognised by the founders.

They purchased an old mansion very near the clinic building, refurbished it, hired a housekeeper, and opened it for the outpatients of the clinic.

The year 1946 will be remembered as the year they were finally forced to acquire an old Army hospital, Camp Plauche, located in the western section of the greater New Orleans area. A day or two after they had made a bid of $150,000 on the facility, and after many trips to Washington for negotiations with the War Assets Board, the newspaper announced that a group of local physicians had organized the New Orleans Medical Foundation and had submitted a bid of $160,000 for the camp site. On November 2 of that year, however, the Ochsner representatives were finally notified by the War Assets Administration that the building was to be sold to them and the permit had been issued for Ochsner to move onto the property.

The foundation took over an old Army hospital (they named it "Splinter Village") in order to get started and to have a place for their patients. They cleaned it up and moved in. In late 1946 they developed a building, called Jefferson House, to serve as a residence for patients who came to the clinic. In 1946 they also opened what was to their knowledge the first family room, located adjacent to the operating rooms. This proved to be tremendously popular with the patients and was visited by many people from other states because of its enthusiastic acceptance at Ochsner.

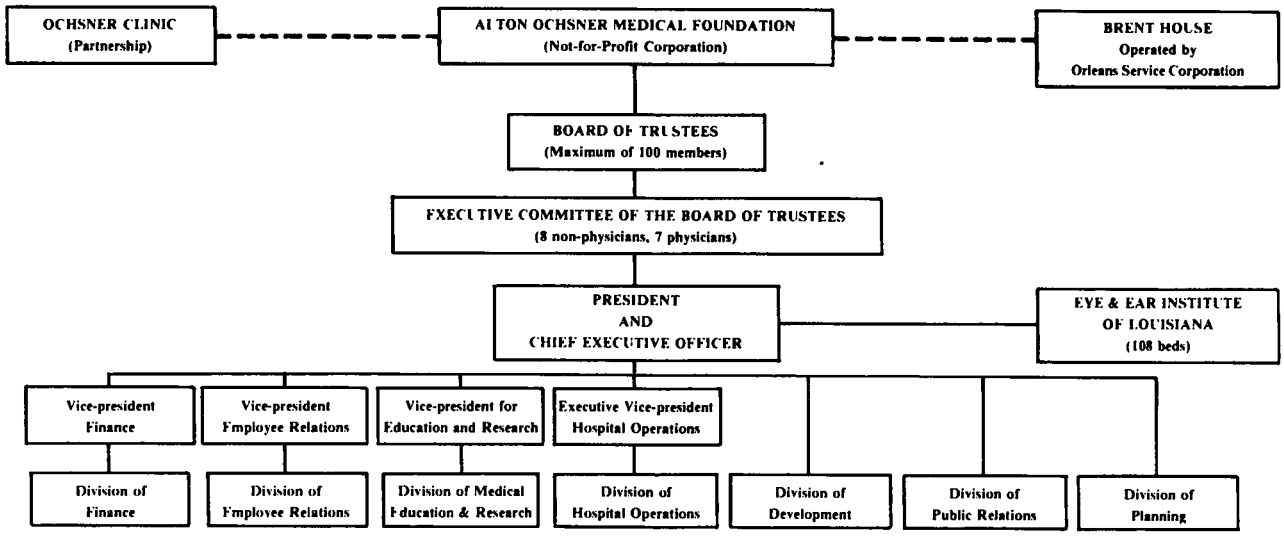
Finally, they opened the hospital with a formal dedication in April of 1947 and started the residency training programs which had just been approved.

Plans for continued cooperation among Ochsner, Tulane and Touro continued even after the final vote from the medical staff. The public members of the board kept talking. It was finally clear to the founders that there was no possibility of association with Tulane and no possibility of association with Touro. They had to move forward the the fund-raising plans which resulted in the acquisition of the new campus located in the western section of the city between Jefferson Highway and the Mississippi River.

It is interesting to note that even in the process of trying to buy the land and get started on a new campus, there was constant and very serious opposition thrown in their way by organized medicine in the greater New Orleans area. The idea of group practice was equated with Fascism, Communism and a few other undesirable things by the medical society. Group practice was very unpopular, and all opposition that could possibly be thrown in their way was mustered.

After starting the hospital in the new location, the present campus, they had several other fund-raising drives which made it possible to expand the educational facilities. A final building program led eventually to the opening of 388 beds. That was our status when we went into the 65 million dollar expansion program which is currently underway and which will be completed by January 1978. This will result in a 520 bed capacity.

I want to close by sharing with you the organizational chart, because I think it covers some of the opportunities as well as the problems that we have in hospital-based ambulatory care clinics.



The board of trustees of the Alton Ochsner Medical Foundation, which meets twice yearly, consists of 50 members and serves in fund-raising and public relations capacities. The executive committee of the foundation is selected from this group.

There are 15 members on the executive committee, including eight public members. A change in the composition of the board took place about four years ago just prior to the expansion program. The public members of the board decided that there was no possible way they would go into the community to raise funds for a major expansion program unless two things took place: first, there had to be a majority vote of public members that had no direct affiliation with the institutions; and second, there had to be a complete reorganization and upgrading of management throughout the organization.

Today, there are eight public members and seven physicians on the executive committee. The president and chief executive officer (the post in which I serve) is elected by the executive committee and in turn selects, hires and fires all of the other employees.

The foundation owns the Ochsner Clinic building and equipment but does not manage it. The Clinic has its own governing body, the Board of Management, which is composed of seven physicians. This board meets weekly.

The Brent House hotel is a modern facility. It includes a health club with sauna and steam room, heated pool with whirlpool, cocktail lounge, florist, two restaurants and a newsstand. The rates are competitive and occupancy level is usually high. Brent House caters to patients and their families and its coverage so that no doctor need be married to the hospital; each one can have time for family, recreation and sports. Opportunities for continuing education without loss of income and time off for research are also considered major advantages of the Ochsner group practice.

What are the disadvantages of the partnership form of organization? There are about three. One is that, under the partnership form of organization, each partner considers himself equal, but you and I know that there are some more equal than others. In effect, each partner is owner and boss.

Another drawback is that, under IRS rulings, you cannot carry funds over from one year to another, so that at the end of the fiscal year all cash assets of the partnership have to be distributed. This is the source of the productivity bonus.

The third disadvantage, as far as I am concerned, lies in the area of malpractice insurance. In the event a partnership should be hit by the courts with five or six, or more, major settlements or judgments that exceeded their limits of malpractice coverage, the personal property and bank accounts of the membership would be subject to being taken over by the courts. This is because the judgment would pass right on to their personal property under the partnership form of organization.

Here are the advantages to the foundation or to the hospital: It gives us a quality control on the selection of medical staff practicing in our hospital. We have a medical staff which brings to the hospital a high degree of loyalty, interest and dedication. We have a faculty for educational programs at no cost, or minimum cost. We have a research capability which results in a large number of publications each year. This helps in recruiting other physicians as well as house staff, and it also encourages patients to request referral to our institutions. Speeches are delivered at major local, regional and national medical and health care meetings. We have an effective utilization control, because we maintain a very high census and all of our physicians are extremely conscious of the need for beds. That is why you will find patients being taken care of in special Brent House facilities who would be considered acutely ill patients in a typical community hospital setting. We simply do not admit patients unless it is absolutely essential that they be hospitalized for appropriate care.

We have an effective self-imposed and self-policed method of medical staff discipline. It works better than any form of medical staff organization I have experienced at either private or state medical centers or at community hospitals. It provides the ability to effect changes rapidly. It leads to a higher quality of patient care, in my opinion, and it significantly reduces the problems that so many community hospitals have with on-call schedules of the senior physicians. It also virtually rules out the threat of boycott, so strong at times in voluntary, open-staff institutions.

We are still in the growth phase, and I think that you would find that in our organization, medical staff and employees are completely sold on the major clinic or hospital-based clinic concept of organizational structure for health care delivery. It does give us the flexibility to move out and to do things on a moment's notice, whereas in an open medical staff, it takes days and weeks to complete the persuasion and to move the

medical staff in a direction that will benefit them. In short, it gives you the ability to respond to local and distant needs.

There is one aspect of the organization that I failed to mention. Many patients come to us from Central and South America. Most of these patients speak no English at all, so the clinic, the hospital and the hotel maintain staffs of full and part-time interpreters. The interpreters do a tremendous job in public relations for our institutions.

Ochsner is an exciting place to be.

Some Case Studies in Ambulatory Care

MR. RONALD WINTER

CHAIRMAN BECKER: Our next speaker is Ronald Winter, an attorney, who is at the Albert Einstein Medical Center. He is Vice President and Counsel at that Medical Center in Philadelphia.

MR. RONALD WINTER: Thank you. I have been working for about two years at the Daroff Division of the Albert Einstein Medical Center. My experience with ambulatory care is a little bit more extensive than just at the Daroff Division. I am going to try to share with you some of my experience in four ambulatory care programs which cover three institutions. Then, I will make some attempt to draw conclusions based upon that experience.

The first institution was the Beth Israel Medical Center in New York City. There were two different programs with which I was involved at that institution. The first was the development of a Comprehensive Health Service on an ambulatory basis. The second was the development of a child and youth program.

The development of the Comprehensive Health Service fell into three basic stages. The first was a diagnostic clinic which began back in May of 1958. The basis of the clinic was that any patient who was not previously registered in another clinic in the institution, and there were almost 70 of them at that time, and who also had not been an inpatient during the prior two year period, and who did not come with a specific presenting problem such as prenatal care, was given an appointment at the diagnostic clinic.

The clinic met during the normal five day week with sessions, Monday through Friday, and handled approximately eight patients during each day. Laboratory work was done on a standard basis. The patient then had an extensive interview with a public health nurse who completed a detailed questionnaire for a history. This included social information, family history, and a review of systems.

The use of the nurse in this manner heralded the beginning of a changing role for the nurse which developed as the Comprehensive Health Service developed at the hospital.

Following all of this, and within an hour after arrival, the patient was then ready to see the doctor. A private examining room separate from other outpatient functions had been arranged. The physical examination took approximately 45 minutes. The results of the examination were then dictated by the physician for later typed transcription, again a first, at least at Beth Israel. Prescriptions and laboratory requests were also completed at that time.

Staffing for the diagnostic clinic was provided basically by interns, residents and some voluntary attending physicians. All were on a rotating basis, and the continuity in the clinic, such as there was, was provided by the Chief Medical Resident.

Cooperation from other elements of the hospital provided immediate availability of laboratory, radiology and EKG. Office procedures were also available, as needed, through specialty consultation, arrangements for which were made on an as-needed basis.

The initial workup also included consultation with an assigned social worker, if this was deemed to be required. The thorough initial diagnostic evaluation resulted in the discovery of large numbers of complex social problems, particularly in the light of the location of Beth Israel which is at the northern fringe of the Lower East Side of New York City.

There was also, because of the immediate availability of the social worker, rapid decision by the patient concerning the medical care recommendations which had been made by the physician. Factors such as the planning for the care of children, family interaction, the employment situation and housing could be dealt with at the time that the recommendation was made by the doctor.

Almost 14% of the patients seen in the diagnostic clinic were admitted during the first two and a half years as compared to an experience of approximately 8% of the patients who required admission from the previous medical clinic.

The main feature lacking in the diagnostic clinic was continuity or coordination of care. The focus was on diagnosing and treating a specific disease. Too often there was less than ideal consideration of the patient as a complete individual and certainly as a member of a family and a community. Disease

prevention and health education were also not included in this setup.

We then moved into the second phase which was the development of an experimental Comprehensive Health Service. In order to meet these shortcomings, a committee on ambulatory services was set up within the hospital. After consideration of the results of the diagnostic clinic and its shortcomings, this committee recommended a six month trial of an experimental comprehensive health service unit. The plan was approved by both the Medical Board and the Board of Trustees of the hospital. The pilot program was not attempted with any intent to change immediately the practices in the outpatient department.

At that time, the department, as I indicated, operated more than 70 separate specialty clinics with care provided almost exclusively by attending physicians who had volunteered their service in partial fulfillment of their obligations for the medical staff membership. The clinics did not function in accordance with an appointment schedule, and the facilities typified an urban hospital outpatient department as was described earlier this morning.

The unit was organized as one single team consisting of two part-time internists on a salary basis, two public health nurses, one social worker, one aide and one secretary. Facilities were set up for the team at minimal renovation cost. Basic changes were accomplished through paint and inexpensive, but attractive furnishings. Private spaces were provided in the clinic facility for examination and consultation by the physician and the necessary interviewing by the nurses and social worker. Assignment of patients was made to a physician and his public health nurse.

The facility was also open during the typical Monday through Friday schedule. Walk-ins during this time were routed directly to the unit. At times when the unit was not open, a card file was maintained in the emergency unit by the clerical staff. The files indicated the identity of the physician and nurse, the current problem and the medical regimen, together with a brief history of the patient. A record of any emergency unit visit was sent to the experimental unit for review by the nurse and physician and inclusion in the patient's medical record.

Six new and sixteen return visits were scheduled each day with appropriate time allocated for the walk-in visits. Time was allocated not only for the physician visit but also for a pre- and post-physician examination interview by the public health nurse.

The role of the nurse was expanded using the time provided through these visits. At the first visit of the patient, the nurse explained the operation of the unit and reviewed the patient's history and presenting problems. The post physician interview provided an opportunity to review the instructions of the physician regarding medications, preparations for tests, et cetera. Telephone contact with the nurse was also encouraged between visits. At subsequent visits, the initial conference with the nurse provided an opportunity to review progress between visits, and also in preparation for the visit, the nurse would review the chart to insure that all lab and specialty consultations had been done and were available. Action could be initiated by her if any gaps were discovered at that time. Thus, time for the physician could be better utilized if any appointment had been missed. The nurse also provided continuity upon admission of the patient.

The organization of the Department of Medicine at that time did not permit inpatient care to be given by the physician in the experimental unit. The nurse, therefore, made visits to the patient if admission was required. She also participated in discharge planning and in arranging follow-up care.

During the experimental phase, it was noted that several specialty consultations were fairly consistently required. Arrangements were then made with the appropriate chiefs to provide these within the area occupied by the experimental unit rather than in that occupied by the specialty clinic.

The experimental unit opened in late 1966. During the Spring of 1967 the results were assessed, and the Medical Board and the Board of Trustees both approved reorganization of the medical clinics along the lines of the experimental unit.

Three additional Comprehensive Health Service units were created at that time with very much the same format as I described above. Operation of these units for an additional period led to the conclusion that the entire ambulatory system at the hospital should be revised. During this period patients were choosing their site of care within the clinics. Increasingly, the choice was the enrollment in the Comprehensive Health Service.

A plan was developed that recognized three categories of service: general, special, and consultive. General services included medicine as organized under Comprehensive Health Service and

pediatrics which also had developed comprehensive programs which I will describe in a few minutes.

A communications bridge was established between these units through the public health nurses in the programs, and this led to the establishment of family centered care. Frequent conferences were held between the adult and pediatric units in order to coordinate care.

As patients were identified in each program, they were checked with the other program. If a family was known to both, a joint conference was held to determine the site of family service.

The second category, specialized services, included those to which patients could be referred directly rather than through one of the general services. These included obstetrics, psychiatry, geriatrics and dentistry. Although initial contact could be made with the specialized service, the patient had to be referred to the general service as quickly as possible in order to enter an ongoing care system.

The remaining services were considered as consultive. Patients could reach such services only through referral from a general service or directly upon discharge from patient status at the hospital. In the latter case, referral to a general service was made as quickly as possible. As expected, there was resistence to this plan during the initial phases. Particularly in the case of the consultive services, there was a fear that they would suffer from lack of patients. Experience proved that this was actually not the case. In fact, the existence of the general services permitted the consultant services to concentrate in depth upon their own specialty.

The intensive initial workup in the service also led to identifying an increased number of cases requiring the skills of the consultive service. Both the actual care of patients and teaching improved in both these areas.

Now we will pass for a moment to the development of the children and youth program also at Beth Israel.

An almost unnoticed section of the legislation which amended the Social Security Act in 1965 to create the Medicare program also provided a program of special grants for the health of school and preschool children.

Grantee agencies created children and youth programs which provided comprehensive health service to low income families. Each project was to define a target area, and the children in that area would be eligible for service. The definition of care was relatively broad including screening, diagnosis, treatment, prevention, corrective services, inpatient care and after care. The primary goal was the delivery of continuing and comprehensive care to these children. In the Spring of 1967, Beth Israel received such a grant. The majority of a former inpatient floor was allocated to the project and renovation was begun almost immediately. The project opened in August, and within 18 months almost 25 children had been registered and were receiving care.

The theory behind the development of the care patterns in this program also stems from an attempt to combat the fragmented impersonal care which had been given in the urban hospital clinic. For the first time, a source of funds became available in order to break this pattern. Care was delivered in the context of a team approach, the team consisting of the pediatrician, public health nurse, social worker and a new member who was called a family health worker.

The family health workers were chosen from the community being served, again the Lower East Side of New York or from similar communities in the New York City area. With the training and basic job skills they had received from organizations such as Mobilization for Youth, the Women's Talent Corps or from OEO-sponsored neighborhood health centers, they provided a bridge between the professionals on the team and the patient. As integral members of the team, they participated in the initial workup and also the development of a team care plan. Often they served as the primary focus for implementation of that plan once it was developed.

The composition of the team led to a longer developmental process for the children and youth program than had been the case under Comprehensive Health Service. Each of the team members obviously had to get to know and recognize the possible contributions of each of the other members. They had to find their place in the course of working together.

Of these four teams which were created, no two of these reached the same balance. Initially, there was a period of lowering of function, particularly among the nurse, social worker and family health worker. Many of the teams began by actually using the family health worker as little more than a translator or a witness to examinations. Gradually, as team discussions occurred and the family health workers began to feel comfortable enough to express their opinion, the team realized the contributions which could be made. The closeness in the relationship between the family health

worker and the patient and the speed with which that developed also was quickly recognized.

The problem of blurring was most acute between the nurse and the social workers. In each case as they developed experience, each moved further into the field of the other. With some teams the blurring never ceased; in others, it did. In a small number of instances this lack of distinction proved to be too much for a particular team member to handle, and they left the program.

Another significant aspect was that of out-reach into the community. The staff included for the first time a full-time community organizer whose job was really one of marketing the program as we recognize the term today. All of the staff were used at one time or another to speak before various community groups. Also, we used all aspects of the community including schools, churches, political parties, block clubs, et cetera.

One of the most important marketing tools was the name which was adopted by the program. During this period a television series entitled "I Spy", was very popular. This was the name chosen by the program as an acronym standing for infant school, preschool and youth. Through agreement with the National Broadcasting Company where the show was being aired, appropriate publicity tie-ins were developed including membership buttons, brochures, and posters.

The program also provided funds for improving the quality of the ambulatory pediatric program in general at the hospital. Support became available for a full-time nutritionist, a pediatric cardiologist, and a pediatric neurologist. A fully equipped audiologic service was also offered. The dental clinic of the hospital was also utilized by the program in the evening and on Saturday.

After the program developed its own patient population, the existing pediatric clinic was folded into it and was eliminated. All pediatric care was then delivered on a comprehensive team basis. The program also developed substantial contribution and communication with the Comprehensive Health Service again, as I indicated, leading to family centered care and allowing the total reclassification of ambulatory care which I reviewed above.

My next experience was in Providence, Rhode Island, and involved an organization called the Providence Health Centers.

Providence Health Centers, Inc. is a community controlled nonprofit corporation, which was created to operate ten storefront health centers which had been developed in Providence. In the mid-1960's the Office of Economic Opportunity set up a community action agency in Providence called Progress for Providence. One element of the agency's program was delivery of health care.

Beginning in two schoolrooms, the health care program soon developed into a group of storefront centers. The growth in this area soon outstripped that of the rest of the agencies, and it became clear that the health arm should become a separate organization. In 1967 this was accomplished through the creation of Providence Health Centers, Inc.

Progress for Providence as a community action agency was based upon the concept of local neighborhood control. As a result of social and ethnic factors in the city, it had been divided into nine target communities. Directors were elected specifically from each neighborhood. Funds were allocated and programs were developed according to these nine target areas. Thus, from the beginning, the health program was fragmented. The same organizational framework was carried over to the new corporation in 1967. The Board of Directors consisted of thirty people, twenty of whom were community based. Elections were held for two directors in each of the nine target areas. Two of the directors came from the Rhode Island Welfare organization and the Rhode Island Senior Citizens Council.

The remaining seats were allocated to the professional community including the major hospitals, the State Department of Health & Welfare, the Medical Society, and two major funding sources, the Model City Agency and Progress for Providence.

In 1971 the Office of Health Affairs of OEO developed the Community Health Network Grant Program. This involved an attempt at linkage between consumers and providers in order to develop a system of care which restructured the services which are already being provided and added services where that was felt to be necessary.

Providence Health Centers applied and was one of the first eight grantees in 1971. By that time it was clear that OEO would be closed as quickly as the Federal Government could manage the process. Due to internal problems, Progress for Providence was already in serious trouble. The Model City Program

was time phased by its nature and was reaching the final phases of its five-year grant program. Thus, its future was also questionable.

PHC, Providence Health Centers, had to find an alternate funding source. It was felt that the network concept, although originating in OEO would be continued in some fashion, and this became the focus of attempts at further funding. Fulfilling the network program criteria, the corporation made several commitments as part of that grant process.

First, a full-time group practice was to be created within the structure of the corporation. Second, nine neighborhoods were to consolidate and six new, in many instances, free-standing health centers were to be built to serve these new areas. Third, the entire program was to be prepaid. A contract was to be negotiated with the Welfare Department which would cover the Medicaid population. Money was available through the grant to supplement payments for the near poor, and the program was then to be marketed to those who could afford to pay.

During this period of development, the existing system was to continue operation. The grant also supported ancillary services including social services, transportation, health education and the training of family health workers and other mid-level practitioners.

Design was quickly completed for a 9000 square foot primary care center. Two of these were constructed within the first two years utilizing funds provided from the grant through OEO. A third center was recently constructed using funds from the Rhode Island Hill-Burton Program. The Model Cities program provided funding for a multi-service center which included in its design a fourth center. The fifth center was incorporated as part of the multi-service center built by the Providence Boys' Club. Proper funding for the sixth center has not yet become available.

Plans for recruitment of physicians were also made. Implementation met with limited initial success. An agreement for affiliation with the emerging Brown University Medical School was negotiated but was rejected by the Board of Directors. This clearly would have improved the recruitment effort since it included a provision for faculty employment at the medical school. Central to the progress towards the prepaid program was the inclusion of a reinsurance agreement with Rhode Island Blue Cross in the area of hospitalization. Negotiations were also completed here and were again rejected by the Board.

A marketing program was developed as were internal fiscal and statistical management systems. Throughout this period the existing storefront fee-for-service system continued to grow at an annual rate of approximately 10% reaching almost 20,000 active patients by 1975. Delivery of service to these patients was continued during the period of planning the new network. The internal problems faced by Providence Health Centers will be discussed in the concluding section of this paper.

We now come to the development of ambulatory care at the Daroff Division of Einstein Medical Center.

Albert Einstein operates two divisions located at opposite ends of the City of Philadelphia. The northern division is a 620-bed hospital affiliated with the Temple University Medical School. It offers a complete range of services including primary, secondary, and tertiary level care.

The Daroff Division with 250 beds is located in South Philadelphia. It is a primary and secondary level hospital affiliated with the Jefferson Medical College. The neighborhood immediately surrounding Daroff is characterized by classic urban decay. The area which it serves, however, contains a substantial lower middle class ethnic population which is actually surprisingly stable.

During the latter part of the 1960's, the outpatient department at Daroff was experiencing decreased volume and increased costs, a high level of unpaid bills and an extremely low reimbursement level from the Pennsylvania Medicaid program which was extremely important to its financial viability. Medicaid reimbursement at that time was made at the rate of $4.00 per clinic visit, and this was an all-inclusive rate. The average cost per visit at that time including ancillary services was in the neighborhood of $20.00.

As a result of the financial burden and the level of care which was typical of hospital clinics at that time, exploration of the creation of a hospital-based multi-specialty group practice began in 1970. The change which would result from this concept would be extensive, having effects upon the hospital, the medical staff and the service community.

Early in 1970 a committee was formed including both administrative representation and medical staff in order to explore the possibility of this change. Early discussions gave evidence of a base of support from the

medical staff, the Board of Trustees, and the administration. An important segment of the medical staff gave early indication of opposition to the plan. Although they would present no alternative solution, they were opposed to formation of the group.

A poll was made of the entire medical staff in order to indicate interest in joining the group. Almost 60% of the staff responded favorably. Based upon this evidence, the Board of Trustees approved formation of the group and allocated funds for renovation of the outpatient facility and also agreed to subsidize the group during its formation stages.

The group began operating in June of 1971 and quickly assumed responsibility for all clinic operations. Opposition among the medical staff grew to the point where it actually included physicians who were participating in the operation of the group.

Acting upon a recommendation of the Joint Administrative Medical Staff Committee, the Board of Trustees dissolved the group in November of 1971. Clearly, it could not function without the supporting commitment from a majority of the existing medical staff. Three members of the staff, each with long records of association and participation at Daroff, began to develop plans for a new group almost immediately. The three included two general surgeons and a urologist.

Their planning resulted in submission of a proposal under which they would form a separate corporation which would become a multi-specialty group practice. Space would be provided to the corporation on a lease basis with payment to be deferred until their activity could generate sufficient income.

The plan provided that they would supply all required ambulatory care services to Daroff through a single system of care based upon the private practice model. The group would utilize ancillary services of the hospital and all members of the group would be required to become members of the Daroff medical staff.

In January, 1972, the Board of Trustees accepted the proposal and the South Philadelphia Medical Group was formed. As a result of experience with the first group practice at Daroff, separate agreements were also signed with members of the departments of orthopedics, medicine and surgery to establish group practices in these areas. These groups did not grow, and by July 1973, all three were voluntarily terminated. The South Philadelphia Medical Group thereafter provided all of the ambulatory services for the hospital in this area.

At the same time, as the initial plans were made for SPMG, a community-based organization known as the South Philadelphia Health Action applied to OEO for a grant to create a prepaid group practice under the network funding mechanism which also had been used in Providence.

Unlike the traditional model, South Philadelphia Health Action did not envision its role as that of a direct provider of care. They saw themselves rather as a coordinator and monitor of care. Instead of hiring their own health delivery staff, they saw fit to contract with existing sites for provision of care to the patients whom they would market and enroll.

After award of the grant, an agreement was reached between South Philadelphia Health Action and the medical group to become the first service site of the new prepaid program. South Philadelphia Health Action provided enormous assistance in the development of the medical group including a substantial amount of start up funding. That relationship continues today, although the vast majority of the patients of the group continue to be seen on a fee-for-service basis.

South Philadelphia Medical Group is governed by a Board of Directors consisting of the three founding physicians. One of them functions as medical director with over-all responsibility for the group's activities. Day-to-day operations are supervised by the group manager. An executive committee composed of the Board and the full-time physicians associated with the group formulates policy relating to patient care and conducts audits for the group.

Functionally, the group is divided into four sections: medicine, pediatrics, obstetrics and gynecology, and surgery. Each section has its own section coordinator who is responsible for the clerical tasks and for liaison between the patient and the physician. Both pediatrics and surgery employed mid-level practitioners. Physicians are associated with the group either on a full-time or a part-time basis. Full-time members receive a salary and then also a percentage of the amount earned above their salary as an incentive. The part-time members at first received 75% of the fees collected on their behalf with the group retaining the remaining portion as compensation for

overhead. The amount retained by the members has since been decreased to 65%.

The group has achieved success from many vantage points. Financially, although the group has not reached a break-even point, the deficit which is supported by the hospital is a small fraction of what would have been experienced under the old model. The Pennsylvania Medicaid program has since increased the payment for hospital clinics to $9.00 per visit, again on an all-inclusive basis. Since the group bills as a private physician, the ancillary services provided by the hospital are now billable for the first time.

In terms of service, there have been many changes as a result of the group. In general, the quality of care has risen dramatically although there is still a long way to go. Patient acceptance of the group and in turn the hospital has also increased. As part of the commitment to the prepaid South Philadelphia Health Action Program, a Patient Advisory Committee has been formed. Early meetings gave vivid evidence of substantial negative attitudes towards ambulatory care at Daroff on the part of the community. Recent meetings show the change in this attitude. In some instances members of this committee have become interested enough in what is going on at Daroff to go on to serve on the Community Advisory Committee which was formed for the entire hospital.

Participation in the activities of the group has been a method of attracting specialists into the community and into utilization of the Daroff Division as their primary base hospital. Obstetrics and pediatrics had been closed at Daroff in 1966 on both an inpatient and outpatient basis. Practice opportunities at the group have attracted specialists in these areas to the hospital, and ambulatory pediatrics and obstetrics and gynecology are being offered again. This year a young ENT specialist will open practice in South Philadelphia using the group as one of his operational bases. This specialty will now be available in the community for the first time in many years.

Service has also been expanded geographically. A satellite was opened serving a community 15 blocks from the hospital. Other satellites are in the planning stage. Clearly, the group has contributed in a great fashion to a revitalization of service to the community and to an upturn at the hospital itself.

What are some of the conclusions that we can draw from these experiences?

In each case the programs which were developed involve major institutional change. The success of each program has a number of things in common. The experience at Providence Health Centers gives evidence of the lack of some of these factors.

Two of the primary factors which I would categorize are: first, a stable institution, and second, a clear commitment by that institution to change. At both Beth Israel and Einstein there was organizational stability. Clearly there were shock waves at both institutions when the changes were made. At Beth Israel, although the clinics were in many ways neglected, they were still considered to be under the personal control of the respective service chiefs. The characteristics of these specialty clinics, particularly as consultative, was a direct threat and obviously created many heated discussions at all levels of the medical staff.

Clear institutional commitment was required in order to achieve the change. It was also difficult to argue with the results first of the diagnostic clinic and then of the experimental comprehensive unit. The small start created on-the-spot evidence of the benefits of change once the initial heat was allowed to cool. Clear institutional commitment was required in order to provide that initial period of cooling-off. At Einstein, the institutional commitment was also vital.

The failure of the first group practice could have ended any further attempts along these lines. Only continued commitment could have weathered that failure with a continued willingness to make attempts along these lines. Providence did not have either a stable institutional framework or the commitment of that institution such as it was. The community was quite satisfied with their storefront centers. The basic reason for acceptance of the OEO grant was really to continue the operation of these centers. By the early 1970's, as I indicated, anti-poverty money was becoming increasingly scarce. The Board saw the grant as an opportunity to continue as they were. New centers and the prepaid program were simply something to be agreed upon only as a means of hoping that what they already had, the storefront centers, would continue. The movement towards the new format really had come more from the staff, and even at that not from the entire staff.

The history of the program was one of a number of communities not only having little in common, but in many instances divided along racial and ethnic lines.

They had come together artificially simply in order to survive. The award of the grant was the signal to return to business as usual and pursue the goals of each individual community.

Only in the case of a new center having been built in a single community where the Board members really represented that entire community and were committed towards the new program as a method of improving care as that center actually succeeded. Today one need only walk through the various new centers to see the difference which is represented by this one.

With regard to the prepaid program, as the organization moved closer to becoming a reality, many of the community Board members realized that the nature of the population being served could very well change if the prepaid program was successful. The effect upon their power base was clearly recognized and predictable action followed. There was not sufficient organizational strength within the centers to withstand this challenge.

A third important factor is the personal background of the person who is behind that institutional change. At both Beth Israel and at Einstein it is felt that somebody from outside the institution could not have brought about the changes which were accomplished. Both institutions were fortunate enough to have members of the medical staff who were sensitive to the need for change and who were willing to commit themselves personally to the new modality of change. This personal commitment in both instances involved long-standing professional relationships, and in some instances personal friendships as well.

At both institutions the men involved had done internships and residencies there and had been affiliated for many years. They literally had grown up with their professional brothers on the medical staff. In both instances there was also substantial personal involvement by the trustees which was very helpful. This involvement also resulted from a long-standing relationship within the institution.

In most instances, the administrator simply does not have that kind of clout. In order to succeed in effecting change, someone must have it and be willing to use it. Probably the key lesson for the administrator is recognizing that power and learning how to use it.

A final point that I would like to make is that in many instances I think we tend to oversell what it is that we are trying to do or sell it on an improper basis for the wrong reasons.

In Providence, the goals of the Board and some of the staff and the federal government were very different. All couldn't have been satisfied, and the administration was not able to obtain agreement on any goals. I would also like to say that the government's role in that situation was very questionable to me also. They tended to take a very passive role in the midst of the conflict. The sense almost is that they drop the goodies into the ring and then they watch the battle to see how it comes out.

The situation at Daroff was originally sold as a fast method to have ambulatory care breakeven financially. I don't think that is really going to be possible until financial mechanisms change. It did dramatically reduce the deficit, and that alone would have been enough to gain agreement on the program if that had been the basis that was used.

Beth Israel started in a very small way. It tested and showed what could be done. Everyone knew what to expect when it expanded. By the time of the complete reorganization of ambulatory care, the ball was already set in motion. I think change can be brought about. It's slow. It's painful, but it can be done.

Some Case Studies in Ambulatory Care

MR. MAX BROWN

CHAIRMAN BECKER: Our next speaker must feel as though he is indeed in hostile territory. As you all know, economics and econometric models, as they are taught here in Chicago, have no relationship with reality at all.

Max Brown, our next speaker, has a degree in Applied Economics, and currently is Vice President and Regional Manager of the Kaiser Foundation Health Plan in Denver.

MR. MAX BROWN: Thank you very much, Professor Becker.

I am really delighted that there is some attention being given to ambulatory care or outpatient care. This area of health care has been long neglected in the health care industry, and it is a shame that it has been ignored.

A great deal of care is provided in outpatient areas. Someone should correct me if I am wrong, but I think that less than half of all national health care expenditures can be attributed to hospitals. That means a lot of health care is delivered in the outpatient arena. It is also significant that educational programs are starting to look at outpatient care and ambulatory care.

When I graduated from a hospital administration program some ten years ago, I wouldn't have known a group practice from a fire hydrant, but that apparently is in the process of being remedied. It is refreshing to see that the Chicago Program is giving some attention to outpatient care.

I am going to talk about three subjects: first, ambulatory care in HMO's, and what I think are some relevant features about HMO's that pertain to ambulatory care.

Secondly, I am going to talk for just a few minutes about the Kaiser-Permanente experience in Colorado because I think that has something to offer the organized systems movement. Then I am going to end by talking about the strength and weaknesses of HMO's.

First of all, let me say when I talk about HMO's, I am really talking about organized systems of health care. I think an HMO is simply one example of an organized system, and we could be talking about XYZ's or ABC's or anything else. HMO's are not in any sense the ultimate answer for health care, but they do represent an organized system, which is generally missing in the health care field.

To begin with, let me make some statements, and some of these I may overstate for effect, but it may keep you awake. HMO's are almost exclusively in the outpatient care business. I was pleased to see a gentleman here this morning stand up and have the nerve to suggest in a room full of hospital administrators that perhaps hospitals really should be considered on the periphery of the health care field. If one organizes care for a defined population, one will quickly discover that hospitals are rather insignificant in terms of providing care to a defined population of 100,000 people or one million people, or ten million people.

Let me cite an example from our experience in Colorado. Just to use round numbers, we will soon have about 100,000 members enrolled in our program there. Those members will make on the average about three doctor office visits per member per year. This is some 300,000 visits in a year. In terms of hospital admissions, we generally run about 80 admissions per thousand members per year, and that is some 8,000 admissions. So just looking at the numbers, 300,000 outpatient visits versus 8,000 admissions is rather significant.

If one thinks in terms of hospital days, we experience generally about 400 days per 1,000 members per year. For 100,000 members we would generate about 40,000 hospital days per year. Still, that is a ratio of almost ten outpatient services for every one inpatient day. Less than 10% of our members will go to a hospital in any given year, but around 80% of them will seek outpatient care during the year. The hospital is indeed, in many senses on the periphery of our program.

These numbers suggest something else about ambulatory care. There is a pressure involved with outpatient care that simply is not there with inpatient care. Our typical medical centers, for example our

outpatient medical centers in California or in Colorado, will see about 1,000 people a day. When the doors open at 8:30 in the morning and there are a thousand people waiting outside to come in and get care, there is a pressure in meeting that demand that does not exist in a hospital. You must have places for people to park. You must have a way to get them inside the building. They must be checked in. They must see a doctor. They must get their lab tests done, x-rays taken and prescriptions filled, and they must get out again. And they must leave satisfied.

Now that kind of pressure really doesn't exist in a hospital. I think a hospital is, however, much more dramatic. There are life and death situations and fancy surgical and diagnostic equipment. But the patients are lying in bed, and most of them probably don't care whether the pills come now or ten minutes from now. There is a certain time pressure that exists in outpatient care that does not exist in inpatient care. It is compounded by the fact, as I noted, that we have not devoted enough attention to outpatient care. We really do not know how to manage outpatient care as well as we know how to manage inpatient care.

And, frankly, maybe Kaiser-Permanente has not been nearly as innovative as we could be in the outpatient area. I think there is a real management challenge to outpatient care, a challenge because there is pressure there. And that is where the action is in an organized system of care.

We have programs around the country turning out people trained in hospital administration, but there are very few people trained and qualified for the outpatient arena.

A focus on outpatient care is of some significance, particularly to those who are thinking about developing an HMO, because HMO's may not have to be hospital-based or to own a hospital, especially in the early years.

The principal economic advantage of an HMO does not stem from the fact that it owns a hospital. It stems from the fact that the physicians control the *use* of a hospital. That is essentially what we have done in Denver. There is no Kaiser Foundation Hospital in Denver. We use community hospitals. But, we are achieving the same hospitalization rates in Denver that we have achieved with our own hospitals in California and elsewhere.

Another reason why it may be advantageous for an HMO or any organized system of care not to get started in the hospital, or why it may be difficult for a hospital to start an HMO, is because hospital administrators think in terms of maximizing the use of their hospital, not minimizing it. If one is to operate an organized system of care on an economic incentive basis, one wants to think about minimizing the use of a hospital, not maximizing it. It is entirely reasonable to talk about an organized system of care that can be started outside of a hospital or away from hospital ownership.

Now, there may be some difficulties in a community hospital with ancillary services because even though the HMO physicians are on the attending staff, they may have some difficulty, for example, in getting block scheduling time in the operating room. There could be closed staffs in radiology, cardiology, and pathology. But I certainly think in the early years of a program's life, it can think in terms of not being hospital based. Again, to overstate, the hospital is almost peripheral.

The second subject I want to cover is the experience of the Kaiser-Permanente program in Colorado. As I said, the Colorado Region of Kaiser-Permanente represents the only operating region of our program where we consciously decided not to build our own hospital. We decided to extend our program to Denver, but Denver was over-bedded. We did not want to compound an already bad situation by adding new beds. We also wanted to minimize the initial lay-out of capital. We went to the community hospitals and asked them if they would work with us, cooperate with us, and extend staff privileges to our physicians. After some reluctance and hesitancy, they agreed.

That arrangement has worked out very well, and I am proud of our program for stepping away from its traditional mode by reaching out and working with the community hospitals. When we went there, we thought we would use community beds for a few years and then probably build or buy our own hospital. But, the arrangement with community hospitals has worked out well enough that I foresee us using community beds for some time in Denver. That makes a lot of sense not only for us, but also in terms of public policy.

We started in Denver in 1969 with about 700 members and some leased office space next to St. Joseph Hospital. By 1973 we had 45,000 members, and we opened our first program-owned facility in West Denver.

By 1974 we were experiencing a positive gross cash generation, and by 1975 we were showing positive net earnings. This year, 1977, we are opening two more facilities, one in East Denver and one in North Denver. We will have four outpatient facilities in operation in Denver by the end of this year, and we expect to reach 100,000 members by the end of 1978.

The planning and operation of a program like this, however, gets increasingly complex with growth. For example, when the program is in one building, it is fairly easy to put the resources there and let the people come to you. When you start spreading out in more than one facility, you have issues such as where should the facilities be, how large should they be, and what services should be offered in each facility.

Another critical issue is what specialities can be practiced away from a hospital setting. A real issue for our program in Denver is trying to decide which specialty, particular subspecialties, can be practiced in an outpatient setting. The answer to that is not clear.

We also have problems deciding what membership base a particular facility should serve. It is not easy to carve up Denver and allocate people to one facility or another because one family goes to one facility for obstetrics and gynecological care, some place else for pediatrics, and some place else for medical problems.

The planning, staffing and managing of an outpatient program becomes quite complex when it starts growing and expanding into additional facilities.

We have been successful in Denver. One of the reasons we have been successful is that we have concentrated on outpatient care. We did not build a large medical center in the beginning, and as a result, that did not drain away a lot of our attention and energy into worrying about a hospital. If we had had a big medical center that probably would have happened. The cash problem or the financial problem probably would not have been as serious as the attention problem. You have got to give a lot of attention to outpatient care. And, if we had had an inpatient center, we probably would not have done that.

An HMO will succeed or fail in the doctor's office, not in the hospital. If the HMO has a young population, it may find only 5% of the membership even going to the hosptial. Even though the member might think hospital coverage is important, and rightly so, if you start probing and actually looking at his behavior, he probably will choose to remain in or leave the plan based upon what happens to him in the doctor's office, in the lab, in the x-ray and in the pharmacy. So though they may think the hospitalization is the most important, because they are going to the doctor's office all the time, that is where they are going to make the decision about whether or not your program is preferable.

Now the third subject—the strengths and weaknesses of an HMO.

Some of the disadvantages have already been pointed out. They are expensive to start, although I don't think exceedingly so. I think a more critical problem is the lack of trained management personnel to run them.

Over the years Kaiser-Permanente has been approached by a variety of parties asking us to extend our program to other parts of the country. One of the reasons the program has been reluctant to expand was because we did not feel there were enough well-trained, experienced management people. As I have already observed, very few programs are producing them. As a result, I think the most significant problem in trying to start an HMO is the staff and management problem, not the cash problem.

We were able to turn the corner in Denver not just because we were well-financed. It is because we had people that could go to Denver that knew what they were doing. They knew how to run these programs. They knew how to get them started and make them operate. That is the difference—not the money.

HMO's are complex organizations that require complex management. One of the most significant problems in trying to get HMO's started is finding people who know how to run one.

The second problem is the need to find physicians who have the commitment to this kind of program. The physician is at the heart of an HMO. No system of organized care can be effective unless it has physicians who are willing to put their souls into this kind of a program.

Another problem is that is is difficult to compete in the group insurance marketplace, although the HMO Act may change this a little. You must remember that HMO's are in the medical care business. They are not in the financial business. An HMO's obligation is substantially different from the obligation of an insurance company. All an insurance company or Blue Cross says to you is, "If you get sick and you are lucky enough to find a doctor and a hospital and you get a bill, we will help you pay the bill."

An HMO, on the other had, has an obligation to provide medical care to people. We say to our members, "When you need to see a physician, we are going to make sure that there is a physician there. And, if you need to go to the hospital, we are going to make sure that there is a hospital bed for you."

When an HMO goes to larger employers, and tries to participate in their group employee health plans, it is limited in some sense because there are many employees scattered all over the area. How can an HMO possible compete for people from all over unless it has a big program with facilities and doctors everywhere, because the insurance company can compete at the mail box. The insurance company is as close to everyone as his mail box. But, if you are in the medical care business, you cannot provide medical care through an envelope and mail it in the United States mails. You must have facilities and people to provide the care.

Another problem is that too often patients tend to judge quality on a basis other than a technical basis. Too many patients think that if the waiting room was nice, and the nurse friendly, and the doctor smiled, they recieved high quality medical care.

I think the recent malpractice crisis illustrated that quite clearly. Somewhere in this country there is probably the world's best neurosurgeon. He is likely in New York, Chicago, San Francisco or Los Angeles. He is probably getting sued a dozen different times every year even though he may be the best neurosurgeon in the world. In the rural parts of this country, you will find country doctors who are not getting sued at all. They could be seriously hurting patients, but they are not getting sued because, after all, it's good old Dr. Jones, right? He always comes to the house when the kids are sick. He always wants to know how the vacation was; what a sweet gentlemen.

People don't have any basis at all for judging the technical aspects of medicine. I think that is a problem with HMO's because they may tend to provide medicine on a more technical basis than some people can judge.

Now what are the strengths of an HMO? First, they are organized systems. I am quite convinced that if the private sector is to retain its responsibility for providing medical care in this country, it is going to have to do it through organized systems. I do not think we can continue to operate for very long with isolated, fragmented providers scattered all over the place: doctors doing their thing, the hospitals doing their thing, the pharmacies doing their things, the insurance company, etc. I do not think this non-system can stand up much longer. We must have an organized system approach to medical care, and I think the HMO represents one form of an organized system.

An organized system must integrate physician care, physician responsibility, and hospital care. It must also integrate the insurance mechanism. It must wrap all of these things up and provide good quality care. I think an HMO, as one form, can do that.

The other significant advantage of HMO's or of organized systems is that they put financial responsibility on the physician, and I think that is where it belongs.

Today we have gone around the edges and considered all sorts of ways to improve the system, but until you can put the financial responsibility on the physicians' shoulders, nothing is going to help. Whatever type of organized system we develop as an answer or as part of an answer to our health care problems, it will have to give the physician some financial responsibility because he is the guy who is controlling the whole show. And, unless you can get to him, you are not going to solve much.

You must place some responsibility on the doctors' shoulders. He must make some decisions. He must exert some control. If he doesn't, I don't think any system is going to work.

Someone suggested this morning that one way to control costs is to charge the patient more money. I just cringe when I hear that. I do not understand how a financial barrier is going to distinguish between a person who needs care and a person who doesn't. I have seen too many examples of women who may have lumps in their breasts who want to go to the doctor but because of the cost, will take a chance and not go. So they gamble, and some have a carcinoma.

I do not think a deductible or a financial barrier to health care is an equitable way to control it. Sure, I think it would control costs, but I think it's a terribly cruel way to control costs. You must get the physicians to take some responsibility. You must get them involved and get them to help organize and control the system. Don't hide behind deductibles or co-insurance or some other financial mechanism. All you end up with are people who can *afford* to come in. The people who may be marginal will not come in; but how do you

know that they aren't the ones who ought to be coming in?

We have got a couple of other problems in health care that I think the HMO may help to solve.

We have a technology problem. Technology, as you all know, just keeps exploding and exploding. It seems that costs go up and the benefits keep going down. We get into high technology items like scanners that are tremendously expensive, and we are not really sure how many people they would help. They do a coronary bypass now on practically everybody who has some chest pain.

The problem is to begin to organize a system to help control technology and make some helpful cost benefit analyses for applying the technology and its utilization.

One point I want to make before I close is that I do not think doctors and hospitals are in any sense villains. I think they are unfairly treated in the press. They are unfairly thought of. Doctors and hospitals simply react—I am talking now about fee-for-service doctors and hospitals—to the economic circumstances that surround them. That is all. They are doing just what comes naturally.

We have an industry based on cost-plus arrangements, and doctors and hospitals are just doing what seems to be natural, given the economic circumstances. And, I think they have been unfairly treated.

What we must change, of course, are those economic circumstances. We must try to develop some form of an organized, systematic approach to medical care. I do not think that we can continue to operate with fragmented, isolated, independent providers all operating on a cost-plus basis. I do not think it is going to work. So, my final thought is that organized systems represent what is perhaps the solution. Maybe they are HMO's. Maybe they are not. HMO's are not perfect, and they have their share of problems. But, at least they bring everything together. They have some reasonably effective incentives to try and provide high quality care to people when they need it, and yet they have some ways to control cost.

DISCUSSION

with Rush Jordan, Ronald Winter and Max Brown, Jr.

CHAIRMAN BECKER: The title of this symposium contains the phrase, "A Critical Appraisal." There has been an underlying assumption for this conference which hasn't been examined at all, let alone critically. We heard this morning the incentives to produce organized systems to provide ambulatory care. We heard some of the barriers to producing it, and this afternoon we heard some examples; examples that are emminently successful and a few that failed.

Given these failures, given the repeated problems of marketing, one could deduce that there is no demand out there for organized systems. If there is no demand out there, or at least not a great deal of demand, ought we to be thinking of stimulating demand artificially and producing these systems to provide ambulatory care?

MR. BROWN: I think it is curious to suggest that there is no demand for organized care systems. We are currently closed for membership in Denver. We are growing so fast that we can't keep up in terms of building facilities and including physicians. If you have a good organized system, the demand is there. That has clearly been demonstrated not only in our program, but programs like Puget Sound in Seattle and a variety of other programs.

I don't think you can argue that the demand is not there because you put together a skimpy little program which may be under financed and run by people who don't know what they are doing. So it goes belly-up in six months, and you say, "Look at that. There is no demand for that sort of thing." Of course there is not. It is like trying to sell a car that doesn't have any wheels and no upholstery or anything else.

In instances where we have presented people with effective choices, it has been clear that there is a certain demand for organized system care.

MR. WINTER: The use of the term "demand" is an artificial one. What you are really talking about is whether there is need. The need is there, and if you have those alternatives available, the demand is there, too.

MEMBER: Would you define what you mean by need? Let's get into that great gray medium, that

middle area. Defining that middle range is precisely the dilemma.

MR. JORDAN: A person who feels like he needs to see a physician has a need. The way the physician handles it makes a big difference, but I think this is certainly a real problem. We have a number of people coming to the Ochsner Clinic for total diagnostic workup that come out of fear, whether it's a cancer phobia or whatever it is, they come out of fear.

You serve a real need when you can help that person who has fear or a need that arises from fear. It's true that some of the HMO's and some of the group practice clinics have had miserable management. They do fail, but the ones that are well managed succeed. With our expansion program now and trying to upgrade almost every aspect, we thought we had built what would take care of increases for at least five years. Our projections are now that we are going to be running capacity again within two years because of the increase in patient population that we are experiencing without even opening up all of the new facilities.

If you can have a facility that will take care of the patient and all of their needs in one setting you are going to find that the patients respond tremendously to it. The major clinic with all of the specialists, the diagnostic and treatment facilities available in one location, appeals to the patient. The patient, in order to get a complete workup, does not have to be referred to eight, ten or twelve different locations.

I concur with Mr. Brown's appraisal of it. The quality of the care that they receive makes the difference here.

MEMBER: When we are talking about a need we seem to be reflecting the time honored emphasis on disease care. And so rather than the woman with the lump in her breast, how about the woman who needs prenatal care? How about those immunizations, and how about just general health education, those preventive programs that will prevent that woman, perhaps not really prevent her from getting a lump in her breast, but that will prevent a lot of things that are going to get people into that hospital?

There are a lot of reasons why people should be going to see a physician whether it is for something that has to do with preventive medicine or something that has to do with just well, just let your imagination run wild.

MR. JORDAN: I certainly agree with those remarks. At the present time, we are studying the feasibility of opening a behavior modification clinic for smokers and in the area of obesity. We are finding so many of the patients that we see are eventually having illnesses directly related to their life-style, the way they are living.

I think the role of particularly the primary care physician is a fantastic role here in working with patients in behavior modification because certainly it is the opinion of our medical staff that a large number of the medical problems that we see could have been avoided if there had been a change in life style.

MEMBER: I am a little concerned about the ethics of marketing. I am thinking about the number of products on the market that are very successful that we could get along very well without. I can recall when health, not treatment for illness, became a right rather than an opportunity, long before we had mobilized the provider resources to be responsive to the demand for health.

I have watched the demand being met in large community health centers very adequately funded for social correctness and creation of happiness in situations where I wish I had a measure of how much the illness that came in for treatment was, in fact, due to the absence of happiness in the situation.

I am not saying that we are not targeted for doing all of the things that we should, but I am a little bit worried about the business of marketing something for which we know there is a need but for which we can create a demand which is far beyond our capacity to meet. That will accelerate the cost which we have already predicted may be shifted from escalating hospital costs to the field of the ambulatory care program.

MR. BROWN: One of the things that our society is going to have to do is decide what level of quality care it wants.

We could put a cardiologist every 15 feet along the sidewalk if we wanted to do that. I think that is rather absurd. The point is what level of quality are we willing to settle for.

MEMBER: If you don't have something like a program where the physician has the responsibility to tell a patient what he needs and what he doesn't need, we are going to have less over-utilization.

For example, how many of us really need an annual chest plate?

MR. BROWN: I think the CAT scanners are another perfect example. I can just see every guy who has a headache getting a CAT scan for $500.00. They really have an emotional argument. How do you know that you don't have a brain tumor? Well, you might have, but at some point we are going to have to make a decision. Do we want to go to the doctor every day? Are we willing to accept some sort of risk?

MEMBER: I have taken a few notes this afternoon and this morning, and I noticed there are two burning questions that haven't been answered. The first one is that we have not identified good management expertise for ambulatory care organizations or situations. The second one is that it seems the only way to control what we are doing is to have some control over the physician and what he does.

The panel has suggested that the HMO is a way of addressing these issues. Can you give some other solutions to those two problems, that is, management, and where are we going to get the expertise for ambulatory care. How else can we control what the physician is doing?

MR. BROWN: To supply managers, we can either train people with existing programs and/or we can have educational programs in the school and university to help train people. I am not really sure that there are enough HMOs to train and produce managers with a surplus that are available for the rest of the country. We are growing so fast that we take everybody we can get and train them and keep them in our own organization. So, we don't really have a surplus of trained people that we can make available to other programs.

The schools, I think, could make a real contribution in this area. They must develop some interest. They should stimulate the students and get them thinking about outpatient care. They must get them thinking about organized systems and get them away from worrying about the boiler in the hospital and which fire door should be open and all that kind of thing.

There is a big difference, in my mind, between program management and facility management. I am not going to take the time to try to carve out the distinction, but what we need in our program and what I think the HMOs need or any organized system needs are program managers, somebody who can manage a program, not just run a facility. It is a real challenge.

As for controlling physicians, the HMO Act recognizes that there is a possibility of giving physicians some financial responsibility even though they are functioning within their own offices. Clearly, that is another alternative to having a group that is bound-up with a health plan. Still, the only way you are going to solve this problem is to figure out a way to make the physician financially responsible for what he is creating.

MR. JORDAN: I want to comment on producing managers because I have had the privilege of serving on the Accreditation Commission that used to be known as Graduate Education for *Hospital* Administration and recently the name was changed to the Accrediting Commission for Education for *Health Services* Administration.

We changed our name because we found the large majority of graduate programs in the United States had changed their curricula, and that they were no longer just teaching hospital administration or institutional management, but in many of the programs you were able to take a special track or major in ambulatory care. They also have courses in health maintenance organizations. So, we found that the trend in the graduate schools of the country has changed dramatically, and though they still teach institutional management, it is not the only thing that is taught. Many of the schools are giving an option.

We are also finding that a number of the larger ambulatory care facilities are developing residency programs in conjunction with graduate programs in health services administration. These shifts in emphasis and in the curricula are going to have a real effect on the future of not only training but recruiting as well as they enter their graduate study.

This is the first governing board in the 22 years that I have been in the field that has had a heavy input from the physicians. They serve on all of our board committees, finance, personnel and so on and so forth. I find that it is by far the best form of organizational structure as far as the Board of Trustees is concerned that I have ever worked with because the physicians do get educated, and they do take more interest in the over-all financial operation of the organization which is the real key.

For too long those of us in administration have had some kind of abnormal fear of having medical staff on the governing board. Unless we involve them in management, I don't think we will ever get our

organizations really under control. You cannot really work out a smooth working relationship with the medical school staff unless they are heavily involved in the management of the organization at the policy-making level.

It certainly is working extremely well for us. I would never want to go back to the board situation that I had in a community hospital where they were all business and professional people from the community with no physicians. The inside-outside board combining a significant number of doctors with community leaders is a real plus. Involving them in your board committees where they have to grapple with the budget and the capital equipment allocation makes a big difference.

MR. JOHNSON: I was struck with the curious position that Rush Jordan took about behavior modification. When he talks about a fat clinic, for example, why should we insure fat people for their health care? Why don't we get some guts about the thing? Why should we insure people if their kids don't have immunization shots?

The State Insurance Commissioners can do this part of the job for us. We insist that people have glasses if they drive, if they need them. So on the one hand, we try and encourage people through education, and then we give them positive incentives not to change their health behavior. I have always found that a strange situation.

MEMBER: How is it that the physicians in the Kaiser program end up getting some financial stake in the economic consequences of what they do? Whenever somebody explains it to me, it sounds pretty good, and then when I get to thinking about it, it seems like there is such a long distance between the decision to order a lab test and what ends up in your check at the end of December or whenever they settle up.

MR. BROWN: I am sure most of the people here are familiar, at least, with the basics of the Kaiser program. We contract with independent medical groups and agree to pay the medical groups so much per member per month for providing physician care. That is a negotiated amount and is guaranteed.

Additionally we say, "If our total program does well at the end of the year and there is some money left over, we will divvy it up with you." I think the issue of whether or not that amount of money at the end of the year is enough to impact their behavior is a good question. I can only tell you that to date I think the experience has shown that it is. The larger we get, perhaps we have to work at it harder to make sure it is. This is the responsibility of the medical group management. They must make sure that the individual physicians understand the implication of their actions and understand as a group that if they generate a lot of hospital expense and a great deal of lab and x-ray expense, there will be nothing left over at the end of the year. This surplus at the end of the year can get pretty significant. The physicians do think about it.

It is hard to give a figure because we have six different groups and it really ranges all over the place, but in most instances it is up in the thousands of dollars, but not more than $10,000.

MR. JORDAN: In Ochsner the productivity bonus is considerably in excess of $10,000 a year.

The fact is that we have never had enough hospital beds, and I feel that if we had a surplus of hospital beds that we wouldn't be seeing eighteen patients in the clinic for every one that is admitted to the hospital. We are taking care of patients in the clinic that when I was in the Baptist Medical Center in Birmingham, the community physicians admitted to the hospital. We have around-the-clock physician coverage, around-the-clock nursing coverage for the patients who are in the hotel, and that does make a big difference.

As to the incentive for the physician's productivity bonus, one of the factors in this is going to be the number of patients that he sees. If there are no hospital beds or if there is a shortage of hospital beds, he is going to put his sickest patients in the hospital, and his other patients, if they live in town, he treats them on an outpatient basis at the clinic. If they are from out of town, he puts them in the hotel.

I think the incentive is there because the productivity bonus is of significance, and I mean greatly significant.

MR. BROWN: I would like to ask you a question, Rush.

When you say that the productivity bonus is related to the patients that they see, do you mean that the more patients a doctor sees, the greater his bonus?

MR. JORDAN: Yes, yes.

We are a tertiary referral center. We are not a primary care center, so our patients are referred in from all over the Gulf, South and Latin, Central and South America.

MR. BROWN: I just wanted to make sure that everybody understands that their bonus is based on something that is 180 degrees opposite from ours.

MR. ODIN ANDERSON: I am directing this question to Max Brown.

What bothers me about the Kaiser model is that it is completely professionally determined. What bothers me about the prevailing structure of service is that maybe it is determined by the patient, too.

In the Kaiser model, if a patient wants certain tests or services on the margin for which the doctor says, "Well, we don't want to pay for it, but we will have the system pay for it," and the patient says, "I will pay for it." Would you allow that exception? Because I cringe at the complete professional domination that you imply in the Kaiser model.

MR. BROWN: Well, to answer the direct question, the answer is no, we wouldn't let them do it even if they wanted to pay for it.

MR. ANDERSON: But next time they can go in to Blue Cross and Blue Shield and dual option.

MR. BROWN: They can go anywhere they want.

MR. ANDERSON: That is your safety valve, isn't it?

MR. BROWN: Sure. The only people who are enrolled in our program are people who voluntarily enroll and do so over the alternative of the conventional insurance program.

Let me make just one comment, though, on the broader issue. It is not completely professionally determined. The reason for that is that we are out on the street selling a product just like everybody else. We must survive. We can't be completely professional because people are not insensitive to what they can get across the street. Somehow we try to strike a balance between what people want and perceive as needed services and what they really need technically. But we still provide a lot of care that we really shouldn't have to on a completely technical basis.

CHAIRMAN BECKER: That is contrary to your earlier position that the patient can't determine between good and bad care or any care at all. Your current position is that you are marketing a product in competition with others. If the patient can't determine what is good or what is bad, is it just a matter of: Is it there?

MR. BROWN: No, what I said was that they can't tell the difference between technical medicine and what they think is quality. They think that it is high quality care to come in and get Penicillin for a cold. They don't know that Penicillin doesn't help a cold. But they think it does, so that they want to come in and get it. They think it's high quality medicine if they get it.

MR. JORDAN: I think that that situation is changing, Max. We are finding an increasing sophistication in the patient.

The public is far more sophisticated sometimes than we give them credit. We certainly detect a tremendous change in the knowledge of the patients about medical care and medical treatment, and that is all to the good. I think that is a big improvement.

My philosophy in group practice is that as long as there is a median income for certain professional groups in medicine, I don't want to be associated with a clinic or a group practice that is not paying competitive salaries. I have seen what happened in some of the governmental agencies and in some of the governmental hospitals when physicians are paid considerably less than the so-called going rate for their services on the open market. We, at Ochsner, are quite different from a primary care center because we have to depend on the referrals from other physicians. We are not the family doctor for these people. We are a tertiary care referral center. That makes a tremendous difference in the kind of operation that we have. Until something is done about the over-all spiraling incomes and salaries for physicians, I think it is extremely important that any institution pay competitive salaries or have offsetting benefits.

One of the things that the group practice does is give the institution an opportunity to work with graduate medical education and a chance for research without loss of income. It gives you a chance for your own continuing education. If you need to go away for six or eight weeks to study a technique, you can go away and that six or eight weeks is not charged against you when the productivity bonus is tabulated.

I think with all of these benefits, you don't have to pay the top of the rate going for a cardiovascular surgeon. You don't even have to go close to it, but you certainly have to be within a reasonable range of what is going on in the so-called private market. Otherwise you are going to end up like some of our city, county and federal hospitals with a medical staff that can't get a job anywhere else.

MEMBER: Are you ever concerned that the financial responsibility of doctors in your system works too well in the sense that the physician benefited financially by limiting services?

In the United Kingdon, for example, they would say

that it is cruel to put the financial responsibility on the physician. Through the capitation system he is free, hopefully, since he doesn't benefit either by providing more services or providing fewer services to his patients.

MR. BROWN: Well, to answer the second part of your question, we have a couple of incentives that deter our people from taking any short cuts. One of them is if you try to defer care and do take a short cut, generally the patient is going to wind up getting worse and is going to come back needing a whole lot more expensive care than if you had taken care of it in the first place.

The second strong motivation we have is that we would like to stay in business. We haven't been in business for 40 years by short-cutting people. We must survive and compete in the marketplace for medical care. If we start taking short cuts with people, we won't be in business for very long.

MEMBER: It seems to me that there is quite a lot of evidence that there is a broad range of professional services that are discretionary. That is, when we look at the outcome we can't really see that these services made that much difference one way or another.

I think many of these kinds of services are the ones where the physician being human as he is, will shade either to serve or not to serve depending on the financial responsibility. Does it really make that much difference in instances whether the patient is hospitalized or not? The question is: How discerning can a physician be, given alternative incentives?

MR. BROWN: I don't know.

MEMBER: There was a time when there was no good data as to how much care Kaiser patients purchased on the open market. Do you have at this point in time an estimate of how much service is purchased by Kaiser-insured patients outside the Kaiser system.

MR. BROWN: We have some limited idea because we have done some surveys. It is fairly subjective, but I think in terms of outpatient care, out of the total care they purchased, maybe five or ten percent of it might be outside the Kaiser program. Inpatient I think it is probably a little less.

MEMBER: It was presented that behavior modification should be with the physician, whereas life style, the emphasis of the Ochsner plan, is aimed at the patient. There is a recent national poll that shows that the public generally understands the cause and effect relationship between poor life style and the end medical result.

You have shown that you can modify physician behavior effectively whichever direction you want to towards more utilization or less utilization with economics, but what about patient behavior and life style changes? Have you gotten into any answers to changing smoking habits or fastening seats belts or the drinking habits?

MR. JORDAN: We don't have any data because we are at the present time planning the opening of these outpatient clinics. We have request coming from the patients that they need help in this area. So our physicians are working on it.

These two clinics will be handled by the Department of Phsychiatry in conjunction with internal medicine. We are also looking at alcoholic rehabilitation, and drug addiction, but we have not gotten into those areas as far as outpatient care is concerned. We are now referring our patients to other clinics, so we don't have any data.

MR. BROWN: I am sure that all of you are aware that from a technical point of view there isn't a whole lot that we can prevent. We talk a great deal about preventive medicine, but there really aren't a whole lot of things that we can prevent.

Most of what we do that people think is prevention is early detection. If we can get people in early enough, we can treat things and prevent them from getting worse. But, we don't prevent them from getting something bad in the first place.

MEMBER: There have been many physicians who have said that because of the professional liability situation they order additional tests for patients.

In the Kaiser plan, is this having an impact on how many services the physicians are ordering? How are you controlling that? Does economic responsibility control that?

MR. BROWN: No, it really doesn't. I would have to say that I guess our response to that has probably been like other physicians. Our physicians tend to get a little nervous, too, and probably have a tendency to order a few more tests than maybe they would have without this spector hanging over them. The real answer to the question is that we don't have a mechanism that prevents that in any way.

What's In It For Hospitals?

PAUL W. HANSON

MR. JOEL MAY: The chairman this morning needs no introduction to most of you. He is Richard Wittrup from the Affiliated Hospitals Center in Boston.

CHAIRMAN RICHARD D. WITTRUP: The title of this morning's session may look a little crass to some people. "What's in it for Hospitals?" I was telling somebody this morning that it doesn't strike me that way. My early exposure to Harvard was when I went over to see one of the officers to make a suggestion to him. I was about three minutes into my presentation. He held up his hand and he said, "Wait a minute, both of us are busy men. Before we go any further, tell me what's in this for Harvard?"

I told him I thought that made sense. So we went on and had a very productive discussion. It explains to you, among other things, why Harvard has the largest endowment of any school in the country. So while I didn't suggest the title, "What's in it for Hospitals?", I am at home with it. The speakers this morning will give us a little insight into what benefits or what troubles hospitals are into if they undertake to respond to what appears to be great interest in the organization and provision of ambulatory care services.

Our first speaker is Paul Hanson from the Genesee Hospital in Rochester.

MR. PAUL HANSON: I do want to begin by bringing greetings to you from the great State of New York. Those of you who have kept up on the economics and on the art of financing in New York, as well as the financing of health care, know that that is all I can bring you because in our state the situation is now terrible. And, we do not want to make this portable. But, if you read Carter's bill, you are reading the economic plan of the State of New York for health care.

I want to begin by telling you a little bit about Rochester and Genesee simply because I am not going to give you a case study of the Genesee Hospital's attempts to formalize an ambulatory care center. I will give you some insight into what I am going to talk about as it relates to the problems we have encountered and where we are at this point in time.

Rochester is a metropolitan area of about 700,000. The city is situated on a lake in northern New York. It is in a county that has eight hospitals. It is of interest that these hospitals range in bed capacity from 80 to 800 beds. That becomes more significant in the State of New York because the State Health Dept. has placed a financial cap on income to the voluntary hospitals, utilizing an unreasonable system of poor grouping. When you put an 80 bed hospital against the University's 800 bed hospital, you will have severe problems from the start. One of the eight hospitals is a county hospital for long-term care. It is the only county tax supported hospital in Rochester. There are no acute hospitals with tax-based financing.

We have a very strong health planning council now in the HSA, and the transition in Rochester to an HSA was very easy. It started about fifteen or twenty years ago and has been extremely strong. Marion Folson who is known to many of you, was the initiator of that planning council.

We also have a large penetration by Blue Cross. They have captured 85% of the market. As we go through these details, please keep in mind that we live in the State of New York. The tremendous powers that are given to the State Health Commissioner by the legislature in the State of New York are crucial to understanding what is happening there now.

The consultant that came to Genesee Hospital from Boston in 1970 used some very gross terms to describe our outpatient department. The physicians and board members were talking about a new facility in which the outpatient department would function. As they became more interested it became very evident to us that we had to take a giant step backwards. We had to do something different than what we were doing, not in terms of the outpatient department, but in terms of the decision-making environment in the hospital.

The main thing we found was that we were dependent upon whether or not the medical staff would be interested or even discuss an issue, while at the same time, knowing full well that they had limited or no knowledge of medical economics.

We had thrown to the medical staff the control of the hospital in terms of the patients, occupancy, and to some extent capital investment. Yet, we had not spent any time teaching them medical economics. So the first thing we did was to back up and try to teach them the medical economic picture for Genesee Hospital.

Though some of them had a glimmer of understanding, we realized that even the Board had very little insight into medical economics for Genesee. They had attended some seminars, an hour here, an hour there, but it was too general to apply to our hospital. I submit to you that the first thing I think we have to do is to take the time to back up and teach our physicians and Board, and in some cases, ourselves, medical economics. The reimbursement principles that apply to your hospital do not apply to my hospital, nor do they apply to all hospitals in your region. In the northern part of our region, which now is defined in this country by HSA regions, we have 23 hospitals. The Genesee Hospital and the three biggest hospitals in Rochester have about 50% Blue Cross inpatients, about 30 to 35 Medicare patients, and 10% Medicaid on the inpatient side.

At the south end of the region, they have about 30% Blue Cross and about 40% private insurance. They have different problems in the State of New York under the tremendous controls of the Health Commissioner than in other states, because in the State of New York we are coupled in all of the factors that control reimbursement for both Medicaid and Blue Cross. Whatever they promulgate on a state health code in the State of New York for Medicaid also becomes effective for Blue Cross. It doesn't take much imagination to see the result of that.

This paradox taught us that in the in-house economics itself, we had to do some additional bookkeeping. For 1970 and 1971 we were not definitive enough in the identification of our cost and our income because we saw on the horizon that there would be controls on financing of hospitals to such a degree that we might have to make decisions on which functions we wanted to keep and which functions we wanted to let go. To make those decisions, we have to have a more definitive income-cost basis because the interrelationships of the functions that you wished to release might have a more disastrous effect on your hospital than you could imagine. We realized that the easiest way out was to take the low-volume high-cost functions and start reducing your hospital. However, we found that the low-volume, high-cost functions were not those that we necessarily wanted to eliminate or shift. The goals that are now established at Genesee Hospital are not reacted to by the physicians, but are supported by the physicians because they were in it from the beginning. The definitiveness of the input that you wish them to have is the key issue.

The other thing we talked about, but didn't understand, was that the Genesee Hospital was to become a center for social change in the community. It was not to become a center unto and for itself, that is, it wasn't going to be an isolated, self-serving institution. Now that is easy to say, but when you try to implement it, we have some other problems, and we will identify those.

We became part of the Industrial Management Council of Rochester. That is an interesting group of industrialists who have had for a long time a fully staffed headquarters that generated a statistical base unlike any place in the nation.

The hospital system decided to become a part of that Industrial Management Council because it was becoming evident that we needed the industrial support to change anything in New York State. They now understand. They now know our statistics. They now know our accounting. They now know our problems and they are helping us in some of the solutions.

But in that light the physicians also are not just given pieces of information that you would like to see them have, or that you think they should have. They have the total financial information of the hospital. The physicians don't sit on the Boards at our hospital, they sit on every board committee, including finance. The budgetary mechanism at the hospital has been enhanced tremendously because of the knowledge of the physicians of medical economics.

When we tried to establish the goals on which the hospital was to make decisions, we found another fault. They had in 1968 engaged a consultant to Genesee who had established what they called the long-range plan. The problem with it, as with many long-range plans, was that it was simply a plan whereby they asked the key people in the hospital, including physicians, what they thought the hospital should do or was doing and then printed it. We destroyed that, made it a paperweight, and went on to make real long-range plans. They way we did it was to analyze, through the economic base every function in

the hospital and why we were doing it. Once we identified what we were doing, we weren't sure why we were doing some of the things that we were doing; but in the long-range plan and in the goals we established from the plan, we set up priorities, and these priorities were adhered to, understood and agreed to by all decision-makers in the hospitals. The goals we set are dynamic. We picked ten. Once those goals were established we then had a collective resource to go out into the community for fund raising, to the HSA, to the State Health Department and to the industrial community. When the highest priority has been accomplished or when it changes, we all agree on the next highest priority and pursue it.

In that era, 1970-71, ambulatory care rose to the top. It rose to the top because the physicians had the traditional problems with the outpatient departments and the hospital had the traditional problems of the outpatient department. In the teaching area we had 33 clinics with residencies in the primary areas. The trouble was that most specialty clinics were covered by our private physicians, as they are in many hospitals. They didn't like it, and certainly our patients didn't. The patients wanted to increase the quality, and most of all, they wanted to change the system whereby they would have social integration, economic integration, and racial integration in our city.

Now remember, we have no city hospital, and that, in one respect, is a blessing, but in another respect we are taking the brunt of all the decisions the State is making in terms of how they are going to finance a hospital. Whether or not we wished to make the kind of decision we made, whether or not we wanted to keep or close the outpatient departments, or change them, or replace them, we had to face underfinanced people in our community coming through our emergency department.

The problems we incurred were typical. There was the financial problem. We were losing about $100,000 a year in 1970. We realize now with our change in accounting and more knowledge in it, we may have been losing a lot more.

Secondly, the ambulatory care physicians assumed the entire operation of the ambulatory department, and what we meant by that was the emergency department and all the ambulatory areas in the hospital were to be under their medical supervision as well as administrative supervision. That was one of the problems we had to overcome.

Third, the medical administrative expertise was missing in the hospital. Often the outpatient department is run by a nurse. There is no clear medical direction, and the conscious effort to make the outpatient department an area of quality and economic breakeven for a hospital is missing because the administration and the Board really has had little interest in that area.

The physician concerns in our hospital were that if we changed to a full-fledged, full-time panel of physicians who would carry on the ambulatory care of the outpatient department, physicians either from the staff or coming to the staff would have to be credentialed by the medical staff for quality control. Secondly, the effect on private practice was discussed. Thirdly, the referral patterns to other specialties and subspecialties were discussed. Fourth, the new patient referrals were an issue. Where do the patients go? This was an issue because we decided that this new ball game was to have the ability to treat any patient, regardless of economic resources, and that meant paying patients as well. Five, where was the location of the facility? And, that had a lot of ramifications. Six, what was the teaching responsibility once this was accomplished? Seven, how were we to manage the appointments. People who were coming out of the outpatient department were traditionally poor, didn't have appointments, didn't even know what they were, were never taught it, and if we referred them to specialty physicians, how would they keep those appointments? Eight, we did not want to continue the escalation of the emergency room use, and would this resolution at Genesee Hospital stabilize or decrease the use of the emergency department? Finally, construction financing was an important issue.

Now here are the results. In 1969, the Genesee Hospital had some foresight, and built the physicians' office building on the grounds, the first one in the City of Rochester. That physicians' office building was built for two reasons. One was that the physicians, those using 100% the Genesee Hospital, asked if they could be on the grounds. Second, they discussed fully with the physicians whether this ought to be jointly owned or hospital owned and leased. They came to the mutual decision that it would be better if the hospital owned it. This again was due to the New York State laws.

The physicians' office building was occupied very quickly; fully occupied by private practitioners with limited use by the hospital. The one floor on the lower level was vacant, and at the time we made the decision

of the ambulatory care full-time practice area, the physicians unanimously agreed that it be built in the doctors' office building and that the entire floor would be allocated, 12,000 square feet.

The compensation for the full-time physicians was to be equal to that of private practice. This wasn't because the practitioners in our hospital were worried about the income of those doctors, rather, it was due to the fact that they knew if we replaced the outpatient department with a new facility and tried to get continuity of patient care we wouldn't have a chance of keeping physicians if we didn't have competitive salaries for the physicians we brought into the hospital in this full-time practice. This was an important decision because the compensation plan that we developed was expanded to all of the hospital now including the full-time chiefs in nine of the eleven areas of the hospital, and the 62 full-time physicians on staff.

In that compensation plan we wanted to do two things. One is that we wanted to include in the hospital reimbursement formula that portion of the compensation called salary in most areas. The salary component would be used only for the administrative and teaching responsibilities of our full-time physicians. The remaining compensation up to a maximum agreed upon with the doctors would be made on fees from patient service. The breakthrough beyond that limit would be a decreasing incentive, and the reason for the decreasing incentive is that our faculty is comprised of both full-time and private practicing physicians. In the full-time area we didn't want them to become so enraptured with the incentive plan that they would lose their responsibility for administration and teaching.

In order to relate the administrative and teaching relationship to the total compensation package we did an audit trail with the physicians to find out how much time they actually spent, or how much effort they actually spent, in these areas. The range now is 10% at the lowest end and 50% at the highest end.

This is becoming increasingly important as the State of New York is reducing the compensation to teaching hospitals in its financing structures. In 1976, it arbitrarily decreased the income to hospitals for house staff by 10%. You made your arrangements with your house staff beginning in July and then, they automatically took away 10% of the income you had spent since January of that year. Now that is power!

In 1977, the State took an additional 10% away which now makes 20% of the house staff salary and added 10% of the faculty base. That was thrown out fortunately by the Federal government because in New York we are matched 50% on the dollar by the government for Medicaid. They left the 1976 decrease in because the hospital association is suing the health department. This is the kind of relationship we saw coming, so our base salary through our reimbursement is decreasing as far as possible.

The clinic referrals turned out to be an interesting result. In referrals to specialty areas, we decided at the beginning that we would refer to the panel of physicians on our staff who were interested in receiving referrals. These referrals had to be accepted regardless of economic status, race, creed, or color. Most of the physicians agreed to this, and did, in fact, practice it.

The referral pattern, then, in the ambulatory care center was made to the physicians on the panel in order, by discipline, as they were needed. Ophthalmology decided that they would go another route. They wanted the clinical aspects of the referral source to be done in their offices on the Medicaid base, and in no way were they going to reinstitute a Medicaid clinic. We have twelve ophthalmologists, and each one took one month, and that month in the first year was the month in which they would take all referrals from the Genesee Health Service. Once they got these referrals, they kept those patients forever until the patient decided to change, which means that every January, Dr. X gets patient referrals, and those patients, no matter what they need for the rest of their time with the Genesee Health Service, are with Dr. X.

Second, ENT did the same thing. This was a voluntary effort on behalf of the surgical subspecialties because of the economics of the hospital which they now knew.

Third, the surgery follow-up clinic which was not necessary to organize in the same way as the other areas, is now being performed in the office of the chief of surgery, and surgical residents and the chief do the surgery follow-up together.

Third, the surgery follow-up clinic which was not necessary to organize in the same way as the other areas, is now being performed in the office of the chief of surgery, and surgical residents and the chief do the surgery follow-up together.

Fourth, the primary care doctors are 24-hour physicians in the Genesee Health Service, 7-day

coverage, and the hours on the hospital site are from 7:30 in the morning until 11:00 at night.

Fifth, the patients have their own doctor. They are fully in charge of the patients. The referral pattern both from the emergency room or to the emergency room, and to subspecialties, is under the control of the physician.

Our patients, regardless of economic status, do know their physicians. They call their own physicians, and they are starting not to come to the emergency room.

The Pediatrics Division had the biggest impact on the ED. There is a study in Rochester which is available to you, if you wish, either through our hospital or the University of Rochester. It was an interesting study of the Emergency Department done ten years ago and repeated three years ago by Doctor William Stratmann. They tried to figure out what the relationship was between what the physician thought was a clear need for the ED visit, and what the patient thought. Over a six month period of time, 35% of the visits were judged true emergencies by a physician examining the charts, while 95% of the patients thought it was a true emergency.

The interesting key note is that of the 95% of those that thought they had an emergency, 50% of them said they would not have come to the emergency room, but they did not want to awaken the doctor at night. The remaining 15% said they really could have waited until morning, but went in anyway.

Regulations are becoming an extremely important part of New York State, and I think that we are probably more regulated than any state in the nation now because of the State Health Department control. We have to respond to 22 agencies mandatorily every time we admit a patient to the hospital in New York State, and those 22 agencies want the same information differently arrayed. When we went into a computerized system and committed our hospital to a computer, we knew full well that we had to set up a system of education in addition to what we had done, so that people knew what was going in and what was coming out of that computer. We knew that we had to respond to 22 different agencies and three additional are responded to voluntarily, for every patient, and we wanted to set up a baseline of information that was also useful to us but which we could use to fill out the various forms. We took the relevant data off the computer, and now we have coming off of it decision-making tools that are understood and not just stacked on desks.

The cost containment programs that we had to go into starting in 1975, had to take 1.6 million dollars out of the operation of our hospital, and in order to attain that, you had better get your docs involved. If you are going to get them involved, you are going to pit department against department unless they understand the interrelationships of economics in the hospital.

We made the reduction with total and complete cooperation from our physicians. This isn't utopia that I am talking about. I am talking about the time it took to inform this pool of infinitely intelligent resources (Board, doctors, etc.) in the hospital that we must make these kinds of decisions.

I think that what many of us in health care are doing is that we are asking them, in their positions of authority in the hospital, to make decisions with little information.

The statistics in the Genesee Health Service are available in many, many studies, and these studies are available to you at Genesee if you write for them. I think there are 17 of them that have been done at the Genesee Hospital, but I will give you just some of the basics.

We started in 1971, and we eliminated every clinic in the outpatient department and started a group panel. That group practice started July 1, and at that time we had *33,000* visits in the old outpatient department. We had identified we think, about 6,000 patients. In 1973, after the first year of operation on a modest start in the Genesee Health Service, we had 40,000 patient visits, and in 1976, 85,000, and this year we will reach 100,000. We have moved to a panel of 17 physicians in all three primary care areas: pediatrics, medicine and obstetrics and gynecology.

There are now registered in the Genesee Health Service 30,000 patients. The interesting part about this is that when we started 90% of the patients in the outpatient department were either non-pay or Medicaid, and the majority were Black or Spanish. That is, of 6,000 patients, 90% were in that category in 1970.

In 1976, we reached 85,805 visits. We had 30,000 patients. The patient mix was 35% Medicaid and the remainder full pay. We have also tripled the number of Medicaid patients under care as compared to the clinic. The economics of the Genesee Health Service are related to the fact that anybody can use the Genesee Health Service. The integration economically has also caused the integration socially. It did work. The laboratory test volume is distorted because our

laboratory is an integrated laboratory with three other hospitals and many, many physicians' offices including group practices. Our laboratory does over 2½ million tests every year, but it is also serving about 1300 beds in the affiliated hospitals. It is doing lab work for about 130 physicians, so we have collection stations all over town. In the Genesee Health Service alone in 1972, we were doing about 49,000 lab tests out of the OPD and in 1976, we were doing 165,000. The relationship is about equal to the number of patient visits. X-ray went up about the same amount in proportion.

The involvement of the physicians in the medical economics of the hospital was one of the key notes that led us into the prepayment concept. In Rochester we have two prepayment concepts, one a qualified HMO and the other a quasi-HMO. The qualified HMO is under the Blue Cross of Rochester, and it is called Group Health and has the largest number of patients. The other HMO is like the one described for you yesterday in the Boston situation which is under the old federal office of OEO. That is the Rochester Health Network which is a group of seven clinics in which six are freestanding and one is involved in the Genesee Health Service at the Genesee Hospital. However, we do all kinds of practice at the Genesee Health Service, including fee-for-service, capitation and other types of insurance.

In the capitation itself we began six months ago, and we have had in that capitation $4.50 per member in the RHN per month for primary care. We have 68 cents per month per member for inpatient obstetrics, $1.78 goes for lab, $1.58 goes for x-ray and $1.20 for mental health. That totals $9.74 per patient per month.

Now the interesting thing is that the physicians knew the medical economics, and they knew that the whole incentive was not to use the hospital. They couldn't figure out how administration can discuss with them the incentive not to use the hospital when we had to fill the hospital because New York State has other interesting barriers. On the one hand they are taking all the money away inpatientwise to operate your hospital, and on the other hand, they have set floors on occupancy. You must have 85% occupancy on the medical-surgical floors and 75% in obstetrics, etc. What they do is then take income away from your reimbursement formula equal to the amount that you don't make in occupancy up to those levels. So, on the one hand, we have to fill the hospital. On the other hand, we have an incentive not to use the services.

Well, it did work. In the first six months with this kind of base, we have a surplus at Genesee of $35,000 in cash out of the prepayment insurance program. On the inpatient admissions, they have gone about equal to the proportion of increase in the load in the Genesee Health Service from the old outpatient department.

The interesting thing about this is that the Group Health prepaid hospital plan out of the Blue Cross is running about equal to what Kaiser is running, about 400 inpatient admissions per 1,000, and the RHN plan is slightly under 600, a little higher. The average for the basic Blue Cross is about 650 to 700 in Rochester. So there is a significant decrease under the prepaid plan of the utilization of the hospital.

When you talk about how your hospital is going to manage a change to the ambulatory section of the hospital, and whether or not you want a full-time physician panel on the site, off the site, or not change your outpatient department or whatever, I think these are the problems you are going to see.

Number one, we are going to take and transport New York State's financial climate into the country at large, and if you don't think New York State's trial-and-error method of reimbursing hospitals is going to go Federal, then please get up-to-date on what the health economics are in New York State. And, when you do, read Carter's bill. Carter's bill is nothing but a transplant of New York State's policy. Governor Carey in New York and President Carter and their staffs have had many, many meetings since November of last year, and if any of you know Dr. Cahill, who is the resource person to the Governor on health affairs, you know it is virtually a one-man show in New York.

But as these financial controls and utilization review impacts are felt across the nation, each hospital must expand their service base in order to hold occupancy level. Where the solvent hospital will exist, one of two things will happen. We will either pit hospital against hospital, and polarize even further that which we have probably done now, or we are going to reduce hospitals in total and shrink the system. We can't all start an ambulatory system, and we all can't expand our base unless there is a tremendous unmet need out there of which we are unaware.

It is imperative that we decide to adopt these changes in the next few months and years. We don't have that much time because the government or the state will do it. The people in New York running

hospitals, managing patients, delivering health care, did not believe it. And, to this date, we still have a few that don't believe it. The facts are it has happened, the controls are there and 23 hospitals will go out of business in New York City this year, their certificate will be taken away by the State Health Department. The intriguing part about that decision is that the Greater New York Hospital Association, the Mayor of New York's Task Force on Health Care and the HSA of New York, all came up with the same list of 23 hospitals, and they will be closed. 15,000 beds will be taken out of circulation, and still some people didn't believe it. As of July 1, one of the obstetric units in Rochester is scheduled to close by HSA decision.

Because these things are happening, people are beginning to believe, and because they are beginning to believe, they are starting to talk to each other until we have a common base of knowledge from which to speak. The tremendous amount of intellectual resources you have in your hospital, unaware of what your problems are, is being abused and misused or not used because we haven't taken the time to explain to them and to the community what this is all about.

Decisions for the future on capital expansion are going to be taken out of the hands of your Boards. They are taken out of the hands of our Boards in New York State right now. The reason is that the Article 28 in the implementation of the Certificate-of-Need of 1966 in the State of New York has now been played to the hilt, and to get anything approved, you must identify the source of payment. You must identify, if it is a donation, who donated. You must identify a complete resume on the donor if it is an individual. You must give a complete financial analysis if it is a foundation.

I also submit that possibly in the very near future in New York and throughout the nation, the debt payment will be paid directly to the lender on debts you presently have, but in the future, you won't see the depreciation allowance which is allowed you and your Boards to make additional program or facility changes.

I think you are going to see new financing mechanisms tried. In New York, we at Rochester are one of the six new systems being tried by the Social Security Administration. Our experiment is called MAXICAP. You might want to keep an eye on that because it might be one of the trial balloons coming down the pike for reimbursement.

MAXICAP is a system whereby the amount of capitation of income for outpatient and inpatient care by all parties involved will be set for a region. Our region has 23 hospitals, and once that is set, the voluntary system will decide how the system is going to be delivered. That service plan is going to be decided against the health system's plan of the HSA.

Now this is a two year plan in program planning. We are six months into it. We have to have it finalized by December 1st of 1978, and whether or not we can continue to talk to each other as 23 hospitals in the next 18 months, is going to be a victory, much less come to grips with how we are going to implement something like this. If we do, it will be for a three year period, starting in 1979.

We also have coming aboard this year in Rochester, an independent practice group of private practitioners. If you have read about the Monroe Plan which is the county medical society's plan, you know it failed. It failed because they didn't know how to practice prepaid medicine and nobody educated the doctors.

This time the I.P.A. is going to be managed on a different concept whereby the physician will be indoctrinated and educated. They are requesting it, and they are selectively signing up, so that the I.P.A. will be another prepaid concept in addition to the Rochester Health Network, and the Blue Cross prepaid Group Health.

We are going to see much more regulation. We have a study in New York, and you can get that from the Hospital Association of New York, in Albany, and you ought to get it to see the regulations that have come down in the State of New York, which triple the regulations coming down from the Federal government. They are totally incompatible. In most of the cases we cannot adhere to the State regulations and to the Federal regulations and still qualify for Medicare, Medicaid and Blue Cross. The reason is that they are completely opposite. When the people come in under the Federal Life Safety Code and the State Health Department reviews separately, we cannot win.

One of the regulations which we all live with, and I would like to tell you about because it shows the ridiculousness of it, is in the windows of your hospital. The State Health Department says, because probably somebody tried to jump out once, that your windows must be locked both from the inside and the outside, and the mechanism must be kept, either key or other, in the nurses' stations. The Life Safety Code, under which you are operating as well as we in New York State, says that you must keep them unlocked

both from the inside and the outside, and access must be allowed by the patient, by the fire department, by you or by me. Now we cannot adhere to both of those regulations. So, when the Federal government came in in 1965, after we opened the new wing of the hospital, they told us that we couldn't comply with the Life Safety Code because we had them locked. The State government came in and said we were okay, but the Federal government almost took away our deemed status. However, the State did get from the Federal government an agreement that we would go by the State rules.

Now we are asking our legislators and our congressmen to get together because we not only are under regulations of both parties, but they are incompatible, and that does reflect a little on the reimbursement we have left.

We have a strong provider support in the input into the planning goals in Rochester, probably more than in many places, because of the strength of the planning council and now the HSA. They have realized that many of the HSA plans are those that will be implemented.

This is the last vestige we see of voluntary planning on a local basis, and if you have the strength transported to Washington that you have in New York, then I would submit to you that it is a good idea to get into the beginning of those health systems plans and the health system agency itself and provide a point of view because those plans are going to be implemented. As I said, July 1st we will probably have one less obstetrical unit in Rochester. In New York City they are beginning to close the 23 hospitals, and they will take 15,000 to 20,000 beds out of hospitals in New York State by 1980.

The last vestige that I see of voluntary control is waning rapidly. This isn't a doom or gloom situation because what we see in New York is real. What we see in Washington is a repeat of that. We see that the voluntary system has to start to control itself in terms of how it is going to deliver. If it is going to continue to pit hospital against hospital in a region, in a state, in a city, we will lose any voluntary input into how your services are going to be delivered.

Third, the public image of Health Care Providers by government, payers, including industry and the general public itself, is at an all-time low. That is simply based on economics, and those economics are not understood either by the hospitals or by the government in most cases.

Finally, if you have an informed, active, collective decision-making body in your hospital, an environment in which you have mutual trust and mutual respect, then you can make those decisions for your hospitals. But I think we are going to end up polarized. I think we are going to end up deciding individually, and we are going to try to make our hospital succeed. The possibility of having any voluntary input into the planning stage seems very limited at this point.

What's in it For Hospitals?

MR. CHARLES R. GOULET

CHAIRMAN WITTRUP: Our next speaker is no stranger to you. Charles Goulet is an alumnus of this institution. He has been an active alumnus for years who finally decided to go where the money was and become Executive Vice-President of Blue Cross/Blue Shield of Illinois.

MR. CHARLES GOULET: When Joel May asked me if I would review some of the activities of Blue Cross/Blue Shield both now and perhaps in the future with respect to ambulatory care, he raised the question: "What are the prospects for reimbursement of ambulatory care in the private sector through third-party payers such as Blue Cross and Blue Shield?"

I would like to start off by simply stating that I think the answer to that question depends more upon what you and your colleagues do in the coming years, rather than what we in Blue Cross/Blue Shield do. To be more precise, I suspect it depends on what you ask us to do with you in developing programs that will impact on both the delivery and payment for ambulatory care services.

It may surprise you to learn that we are deeply in this business already. Some who are unfamiliar with Blue Cross and Blue Shield are very surprised when they learn that Plans in this country process far more claims for ambulatory care services than for inpatient services.

The other day when I was preparing for this morning, I looked at our financial report for the first three months of this year. During that period, we processed six times as many individual claims for outpatient services as we did for inpatient stays. For the same three-month period a year ago, the ratio was one to five and a half.

Part of the increased volume is, of course, due to the increased sale of ambulatory care benefits. There are still a number of groups that do not have these benefits, so the claims volume increase is not directly related to the increased use of ambulatory services.

In other words, providing benefits for ambulatory services is big business for Blue Cross/Blue Shield, and it is likely to take on even greater significance in the future.

I would like to just take a minute to categorize some of the benefits that the Plans around the country do provide for ambulatory services. Most of these are the same thoughout the country, although there are regional differences that you will recognize and you are more familiar with than I am; but I think it's fair to say that the coverage patterns are more or less consistent, if for no other reason that that the Plans are dealing with a number of nationally negotiated programs, auto, steel, communications, and so forth.

In the first category of benefits, I would put those that are traditionally offered as a part of basic Blue Cross/Blue Shield coverage. In our case, it would be a rare group that did not have these benefits, and then only through a special rider that excluded the services. These benefits include coverage for emergency care for accidents and injuries, diagnostic laboratory testing done on an ambulatory basis prior to admission for a surgical stay—the so-called "Pre-admission Testing Benefit", coordinated home care, ambulatory surgery, outpatient dialysis, and coverage for day and/or night psychiatric care. A more recent addition to benefit programs in this category is coverage for emergency medical services—a benefit which is extremely difficult to administer and which, by and large, has been limited to services received in a hospital as distinguished from the benefit for surgical emergencies which covers care regardless of the site in which the service is received.

A second category of benefits are those which are purchased as additions to basic coverage and are often paid for under indemnity fee schedules or under deductible and co-payment formulas. These benefits are usually referred to as outpatient diagnostic and therapeutic benefits, and include payment for x-ray, laboratory, radiation therapy and rehabilitation services. These programs do not limit payment to services received in a hospital, but usually cover services regardless of site.

A third category of benefits is beginning to emerge in connection with the negotiation of some national contracts—particularly those of the auto and steel industries. These programs may or may not be subjected to deductible and co-payment arrangements. They include prescription drug programs,

vision care and hearing aid services. There are a number of issues that have arisen concerning payment for these benefits that are likely to complicate our life for the next year or so, until some consensus on standardization of these benefits emerges. For example, there is a continuing debate over the role of optometrists in the vision care field and of audiologists in the hearing field. This is not unlike the controversy which has been raging nationally over the role of the psychiatric social worker as an independent practitioner.

There is yet another group of benefits that we sometimes overlook when we consider pre-payment coverage of ambulatory services, that is the major medical program which is characterized by both deductible and co-payment features. Historically, such benefit programs have been subscriber administered rather than provider administered. That is, the individual who has the coverage is expected to accumulate paid bills and submit them to the Plan at periodic intervals in line with the deductible features of his program and receives reimbursement from the Plan rather than having payment made to providers. The availability of this coverage is expanding greatly and a number of Blue Cross/Blue Shield Plans, including our own, are moving aggressively into this market, as one means of capturing those groups which have traditionally avoided service benefit programs in favor of low indemnity, and high deductible coverage. Indeed a variation of this concept of benefit has most recently found its way into the hospital and health insurance market. It is what we might call "comprehensive major medical" which, unlike the traditional major medical, is not built on a basic benefit program, but rather stands as the only coverage held by the individual. Thus he shares the risk for a specific front-end dollar amount, and on the other end, the benefit limits his out-of-pocket risk to a specific dollar limit with full service coverage occurring after that "out-of-pocket" limit is reached until a maximum benfit pay out is reached. We are even writing some programs with unlimited benefits, that is, no maximum benefit.

This is an interesting concept that we may hear more about because, among other things, it provides an answer to the major criticism leveled at the health insurance industry, and I might add, more particularly at Blue Cross Blue Shield. That criticism is that with expansion of employer paid health benefit programs without employee contribution, there is little, if any, recognition on the part of the employee of the extent of the value of the coverage he is receiving from his employer.

You are all as familiar as I am with the debates which took place last year between the auto companies and the UAW concerning their contract negotiations. Although the debates will in no way reverse the type of coverage that is made available by that industry, the issues that were under discussion have not gone unnoticed by those employers who are still able and willing to include an employee contribution in the payment for health coverage programs. For this reason, comprehensive major medical does have some appeal, and, if I am not mistaken, we have been offering it here at the University as of last fall.

Finally there is a fourth category of ambulatory care benefits that we might classify as capitation benefits. We tend to think of these benefit programs under the general rubric of Health Maintenance Organizations, but in point of fact, they are what I like to refer to as alternative arrangements for the delivery and financing of personal health care services. 39 of the Blue Cross Blue Shield Plans are now involved in 55 different programs (Paul mentioned one this morning) a third of all such programs available in the country. Enrollment now exceeds 2½ million people and it is climbing each month, both because of further development of programs and because of increased enrollment in the existing programs. I will have more to say about these programs and about the opportunities they offer to hospitals a little later.

I suppose we ought to consider the rationale for the marketing of ambulatory benefits. Historically, it has been two-fold: first, and I might add, with great stimulation from the provider community, the argument was advanced that the utilization of costly inpatient services would be moderated by the introduction of ambulatory benefits, particularly those that cover outpatient diagnostic and therapeutic services. Such reasoning was also applied to coordinated home care.

The argument would seem to make sense, but in fact, there is no study which has been completed by a Plan in this country which would demonstrate to the satisfaction of the prospective buyer that the introduction of these programs will materially affect the utilization of inpatient hospital services. Conventional wisdom would tell us that it should. But, the difference in utilization between those groups

which have such coverage and those that do not, is statistically insignificant. Similarly, despite the efforts of most Plans, and I might add, most progressive hospitals that have introduced home care programs, there is very little evidence that such programs materially affect the length of stay on a diagnosis specific basis.

I think it is fair to say that most personnel and financial people who make the decisions with respect to health care coverage for major industries, have come to the conclusion that these benefit programs are truly programs to expand benefits for certain services, and only incidentally, impact upon the utilization of high cost services. The argument for offering these benefits centers around the concept of expanding coverage rather than the case for cost containment.

It is worth noting that this is not a bad rationale. It has, in fact, responded to marketplace needs, especially in the area of negotiated fringe benefit programs which place major emphasis on first dollar coverage. It has, however, tended to further minimize the individual's involvement in the economics of his own health care, a consequence that we may all live to regret.

As a sidelight, I should point out that we are under increasing pressure to pay for services which are labeled as "inpatient diagnostic." Despite all of the arguments to expand payment for outpatient diagnostic care, a number of groups are now insisting that when patients are admitted to hospitals for diagnostic test purposes and there is no sound medical reason for such admission, that the individual patient should not be held responsible for anything more than the room and board charge. In other words, benefits that would have been available on an outpatient basis should be made available on an inpatient basis.

Well, what conclusions can we draw from the present state of affairs?

First, I think it is fair to say that coverage for ambulatory services has been largely on a piece-meal basis with little, if any, integration of the pre-paid benefit program in terms of incentives to physicians, institutions, other providers and subscribers to alter traditional delivery patterns. And, secondly, there is little evidence that the expansion of benefits to cover ambulatory care including substitutes for in-patient care, have materially affected the utilization of hospital services, except, of course, the use of diagnostic and therapeutic services by outpatients. The problem, of course, has been that benefit programs directed at payment for ambulatory services have not been intended to encourage institutions or physicians to change the patterns of utilization. The reason has been the failure of these programs to cover primary and secondary physician services. And, it is my contention that there will be little incentive for hospitals, and their physicians, to alter present utilization until there is a fundamental change in the payment arrangements for these primary care services.

One might ask why insurance carriers such as Blue Cross/Blue Shield have not provided for payment of these services except under some Major Medical programs. The fact is that there is little that can be done to control the utilization of these services except where they are delivered through some organized or institutional arrangement. You will recall that it was the high utilization of physician services under the Medicare program that led Paul Ellwood and others to the conclusion that the HMO concept had merit. You may or may not agree with the conclusion that delivery must be organized or institutionalized, but I can assure you that there is a general reluctance on the part of Plans, based upon some pretty solid evidence that such benefit programs would be both costly in terms of payments and equally costly in terms of benefit administration if risk sharing and/or peer controls are not built into the delivery process.

What, then, should be the role of the payer in improving the availability of ambulatory health care services?

I personally believe that it is the organization—that is, the delivery of and the payment for Coordinated Health Care services, beginning with primary care—which offers the greatest challenge to hospitals, physicians and to payers like Blue Cross/Blue Shield. The institutionalization of health care services that has been going on over the past two decades will continue. At the same time, there is greater and greater recognition that the so-called "laissez-faire" system for the delivery of personal physician services is not going to be entirely successful in meeting the needs of many of our people. Coupling this with the mal-distribution of physician services which results from specialization, the challenge to hospitals, physicians and to us, is clear.

Unfortunately, I suspect that the image of the dispensary or free clinic is still with many of our urban medical centers, and may be for some time to come. Nevertheless, it is encouraging to see many of them turning to group practice models for the delivery of

primary and secondary services. It has always seemed unfortunate to me that group practice has been characterized by the concept of sharing of income among physicians, when, in fact, of equal importance should be the concept of sharing of expenses, including the expense to the public of receiving coordinated personal physician services.

It is my own feeling that such programs will be developed more rapidly and more soundly in those hospitals which clearly set corporate goals for themselves that get at these issues and I mean corporate goals as distinguished from long-range development programs.

The mounting of specific programs might be far less difficult if the issues of corporate purpose could be threshed out by boards and medical staffs before institutions embarked on these programs.

I might add paranthetically that I personally find it hard to see any answer to the need for health care services in our rural communities except that which is built around the corporate commitment of institutions in rural centers to provide health care services to a large rural population through the utilization of the group practice concept coupled with institutional governance and management. We have one medical school in this state, Southern Illinois University, which was developed on, and still is firmly committed to, this concept.

Some of you know Dick Moy who used to be here at the University. He ran the student health service. He has had some distinction, being one of the few deans who both planned and opened a medical school, and is still leading it.

Dick is firmly committed to the concept of training people for rural health and trying to work with institutions in the Southern part of the State to develop the group practice concept.

Finally, it seems to me that Blue Cross and Blue Shield have an obligation to work closely with you in the hospital and medical community in helping you develop and finance programs that are initially experimental, and then to market on an on-going basis those programs that offer hope for success over a longer period of time. I hope we are trying to do that in Illinois. There is a great temptation to describe three such programs with which we are associated. To be sure, these programs are built on the HMO concept and they carry with them a prospective capitation payment. The minute that this is mentioned, a number of you are discouraged from proceeding further. Let me assure you that this need not be the case.

It seems to me that we ought to be able to design financially sound programs, for the provision of ambulatory care services by institutions, including the provision of medical and surgical services by members of an institution's medical staff, which include reimbursement on some fee-for-service basis. Indeed, it might be a prospective fee basis.

Up in Wisconsin the Health Maintenance Plan now has between 140,000 and 160,000 people under such an arrangement. Such programs could be marketed on a dual or multi-choice basis. Their long term viability would have to be evaluated in terms of their real effect upon both the accessibility and utilization of total health care services, as well as upon the pre-payment aspect.

In addition to the support which, I believe, we as payers must give to the development of experimental programs, I think we have a further obligation to alter the financial arrangements between the public and providers and where appropriate, to provide incentives to institutions and physicians to embark on new programs.

Let me give you two brief illustrations.

The present systems of reimbursement, most notably those under the federal programs, provide dis-incentives to what I call "differential pricing" of out-patient services. Thus, the hospital is at a competitive disadvantage with free-standing facilities, such as independent laboratories, ambulatory surgery centers and the like. I think that we, as well as other payers, including the federal government, should come to grips with this problem and solve it with you.

The second issue is that associated with the accumulation of capital for the development of ambulatory services. It is no secret that we will be working more aggressively at the national and local levels in attempting to provide financial incentives to institutions to broaden ambulatory services, most notably in an effort to reduce the heavy emphasis upon inpatient services. Indeed, the heavy dependence upon borrowed capital for the construction of in-patient facilities has got to serve as a dis-incentive to reduce in-patient occupancy unless some alternative use can be found for that capital.

I think we must play a role in that thrust.

There are other problems that we both could identify. Well, where do we come out from our side?

First, most Plans, I think, are interested in working with hospitals and physician groups and coupling the prepayment principle, with primary as well as other health care services.

Second, we are looking for opportunities to develop experimental models that offer some hope of success not only in meeting the country's demand for payment but of equal importance, of meeting its demand for access to coordinated and integrated personal health care services.

Some of you I have heard since I have been here say that the future of hospital administration is bleak, indeed. Well, perhaps here is an oppoortunity for us to work together to make it more satisfying and rewarding.

What's in it For Hospitals?

MR. STEPHEN M. WEINER

CHAIRMAN WITTRUP: Steve Weiner is Chairman of our Massachusetts Rate Setting Commission and has qualifications for this "bad guy" role. For one thing, he is a Harvard graduate and I must tell you that he is not a total stranger to these parts, having been a National Defense Fellow in political science here at the University of Chicago back in the 1960's. But, his dedication to free enterprise economics, I guess, didn't take totally when he was here, so he is now back on the government side of things.

He is known among us as a sort of a discouragingly bright fellow who seems to know how to get a handle on these problems, and as I say, that is a little discouraging from the provider side. But all in all, we manage to maintain a reasonably good relationship and I am very pleased to be able to introduce him to you today as our last speaker on this program. I think you will enjoy hearing what he has to say.

MR. STEPHEN M. WEINER: that introduction is a little bit difficult to follow, I am afraid. I was trying to figure out exactly why I was the last person on the program, particularly on a Saturday morning. I suppose it is either because I am very controversial, and therefore, it will wake you up or because no one wants you to hear what I am going to say. You can take your choice on that.

Particularly after Paul Hanson has talked about some of the New York issues, I thought what I would do very briefly is to describe what we are doing in Massachusetts in terms of control programs and then talk more specifically about the topic which I think I will have a chance to address.

Massachusetts is more aggressive and less progressive than New York State. We actually run three different regulatory programs for hospital rate setting.

One is the Blue Cross Program where we approve the contracts that Blue Cross has with hospitals. One is a prospective Medicaid system patterned after the New York system, although leaving aside certain of its trappings, only for the inpatient rates for Medicaid purposes. And, the third one, where I think we are more aggressive, is that we have actually begun to knit the entire system together into one of the best statutorially mandated hospital revenue review or bank review programs in the country. We are actually in the process of establishing charges for the institution and allowable revenues which act as a ceiling for all reimbursement parties. Some people in the State hope that our Blue Cross will become a uniform rate system eventually.

The experience we have had, has been very instructive because essentially what we have been dealing with is a two step process.

One is trying to get a handle on existing problems, and trying to begin to introduce some cost accounting kind of concepts. The type of responses from the hospital that Paul Hanson has described that occurred in Genesee, is very instructive and useful because by and large, we are trying to get the hospitals to understand their responsibilities in dealing with the regulatory system, and particularly trying to develop a relationship between the hospital trustees, administration, and the medical staff, especially in terms of dealing with cost-containment issues, and, if you will, the restructuring of behavior patterns to produce more "cost effective" conduct, whatever that means. But that is one of those terms that I am supposed to use when I get up and talk to people.

We have spent a fair amount of time, by the way, trying to explain the objectives and the policies behind the regulatory system, so that the hospital will respond in the appropriate fashion. Hospitals are very good, as are other parties in regulatory systems, at responding inappropriately, and we are hoping to be able to redirect those energies in a more constructive fashion.

That is the second phase of what we are trying to do because we really view regulation in the health delivery system as a means of restructuring the system. One views it, when I am in my rhetorical flowery kind of mood, as an alternative to much more strenuous and perhaps much more desirable governmental regulation or intervention. Actually, governmental intervention in the system, because of the difficulties with trying to maintain both equity and some cost restraint in the health delivery system, is less desirable.

So the regulation really ought to be serving the

function of redirecting or actually, in a basic sense, restructuring the system. We, for example, view one of our major responsibilities as dealing with alternative systems like the HMO's.

We are beginning to look at longer term issues from the point of view of where the health system ought to be. Ideally we hope to begin to minimize the direct impact of governmental regulations on the system by restructuring incentives. It all sounds terribly idealistic, and it is very difficult, and it is one of those things where, we may not get to see it in our time, but maybe the seeds are being sown.

In that context, trying to get to the issue at hand today, one of our responsibilities, is to look very hard at anything dealing with hospital behavior and its cost implications. The issue we really deal with on an ongoing basis is the policy question of the extent to which we ought to be using our rate setting authority, which has grown increasingly over the last few years, from the point of view of orienting or redirecting hospital activities.

It is in that context that I want to briefly talk about the question of what is in it for hospitals from the point of view of ambulatory care services. I suppose I would like to rephrase that question to a certain extent to discuss what, from the rate setter's point of view, is the benefit of having hospitals engaging in ambulatory activities.

The first point is basically that we don't really know the cost of ambulatory care services in hospital settings. I think it is one of those startling statements that needs to be made periodically. We have a lot of assumptions about it, and we think we have a lot of information. Most of it, I must say, is fairly useless.

For example, of those who are intimately familiar with the abstractness of rate setting terminology, the existing allocation methodologies that are used, for example, for dealing with routine and ancillary services, inpatient and outpatient and so forth, really don't, by and large, produce a very rational basis for determining which costs are associated with inpatient areas of the hospital versus which costs are associated with the outpatient areas of the hospital. We use for our Massachusetts programs, leaving aside Medicare which I prefer not to discuss at all costs for Massachusetts programs, a fairly elaborate step-down methodology. We have been accused of this before, but I do not believe that the step-down approach that we use really does an adequate job of determining what the actual outpatient expenses are. That is, the real costs of the institution associated with the outpatient area.

Now one can argue that that is not necessarily bad from the point of view of the hospital, because as you have heard, one strategy for hospitals in response to the kinds of cost pressures now on the hospitals is to begin to expand into ambulatory areas as a means of spreading its costs. In which case the more inpatient costs that get spread to the outpatient area, perhaps the better it is from the hospital's point of view, particularly in the situation where its inpatient revenue or inpatient cost is being controlled, as, for example, would be the case under Carter's current proposal, where outpatient revenues are not subject to the control mechanism, at least, as of the last draft that I have seen of the Bill. I don't think that there are going to be changes for a while.

In Massachusetts, we have even more obscured the possibility of determining what the costs of outpatient services are because of some of the techniques we have used. For example, Medicaid outpatient rates are determined on the basis of a ratio across the charts, determined historically and applied to the current charges of the institution. In that kind of context, we really never have to look at the actual costs of the outpatient area except on the basis of a rather arbitrary allocation methodology that we discussed. Since most hospitals are at or near one hundred percent, indeed, most of them are over one hundred percent, we limit them obviously to one hundred percent of charges. We don't get into the determination of the actual costs of the services.

Our friends at Blue Cross—I guess I will have to use a kindly term for it—have an even more arcane way of dealing with the situation because they merge the ancillary inpatient costs with the outpatient costs for purposes of determining the classic formula of lower of cost or charges, so that in fact, it is a very human incentive on the hospital's part to make a distinction between the outpatient costs as a whole and certain major inpatient costs such as the ancillary areas.

There have been efforts to try to make some determination of the actual costs of outpatient services. Those of you who are familiar with some of them, I believe it was the 314-E programs, where there was lending for the expansion of ambulatory outpatient services in certain large municipal hospitals. Denver, San Francisco, and I believe, Boston at Beth Israel, had one of those grants. There was an attempt, in fact, to do an allocation of the

hospital costs that would more accurately determine which parts of the overhead really were associated with outpatient activities. The thrust of that effort was to try to indicate that outpatient areas really cost less than everybody thought they cost. That is, lower units of costs to produce lower prices. The grants produced an inducement, I think, for more people to make use of the outpatient areas.

There were some efforts going on in Boston. One of the constituent divisions of Quaker Supplies is looking very carefully at the outpatient area, trying to make some determination of what the actual costs are, leaving out the arbitrary allocation approaches to the outpatient area.

As I said, the strategy may be to show that outpatient doesn't really cost as much as people thought it did, and therefore, may not, in fact, be as much of a revenue loser as is often assumed to be the case.

Hospitals, by the way, are not alone in this particular problem of determing the cost of services. We have tried to look, in the last few years, at the cost of providing ambulatory services in the non-hospital situations such as neighborhood health centers, mental health clinics, home health agencies, and so forth. With all due respect to the hospitals, these other institutions' level of sophistication in determining their cost is even lower than the hospitals'. We have spent a fair amount of our own staff energies trying to develop cost reporting systems for neighborhood health centers, and we are slowly beginning to try to make some sense of what the actual costs of operations are in those kinds of institutions.

Again, that would be constructive from the points of view of doing a comparison. Once we can determine what the costs are in the hospital outpatient area, we can begin to make some relevant, germane comparisons with non-hospital-based settings to try to determine which, in fact, is a more cost effective setting for dealing with this kind of problem.

I will make one additional comment on that in terms of the efforts to determine the true cost of outpatient services. For example, under the 34-EE type program, the efforts to determine the true cost of outpatient services independent of any of the more arbitrary allocation methodologies that have been developed, raises the question of what happens to all the costs of inpatient services that used to be ascribed to the outpatient area that might no longer be if that kind of a system were put into effect. All things being equal, and nothing else happening in the system, all that would mean is that inpatient costs will increase. As I have indicated before, that may not be desirable from the point of view of most hospitals given the current construction of most regulatory systems dealing with rates and costs. So that is not a very encouraging line of inquiry right now.

From a policy point of view, I suppose the conclusion I would have to draw from these kinds of comments is that until better cost information is available, it is not clear that we should be making a definite public policy encouraging hospital outpatient activities. It may cost us more in terms of unit costs, particularly in comparison with non-hospital settings.

As I said, we really don't know at this point, but I think in the absence of knowledge, it is often better to take a more conservative stance than the easy rhetoric, that we must always seek increasing hospital involvement in ambulatory areas. We may, at least for the time being, want to be somewhat constrained until we have better cost information.

I want to make a distinction which rate setters love to make nowadays between unit cost which I have been discussing and total cost which is most simply put as unit cost times volume. We must look at the ambulatory area from the point of view of total systems cost as well.

The question, I suppose, is: Will the encouragement of outpatient ambulatory activities help reduce or contain total cost, and not merely involve the use of a lower unit cost types of services? It is a rather more difficult question because it raises a whole series of issues about utilization patterns which I will briefly comment on.

In looking at that question from our perspective, I think it is important to make a distinction between demand conversion and demand expansion. In the health system, the expansion of providers into new areas often has the effect of increasing demand because of an increasing availability of services. That, I think, is equivalent in Blue Cross experience as it moved into the area of expanding health insurance benefits for non-inpatient activities.

In some areas, particularly where primary care needs are undeserved, and there are clearly places like that left in this country, it may be desirable for this to occur. The expansion of services and also the entitlement of services will produce greater demand

for the services. More units will be consumed and that will produce an increase in total cost even though on a one-for-one basis, the unit cost may be less by doing it that way. Because of the increasing demand, you have an increase in total cost.

That kind of expansion in underserved areas is not and cannot, and indeed, should not be viewed as a cost savings device, although rate setters like to talk about cost saving devices. It is not a cost saving activity except to the extent—and here is a slightly speculative statement—that early intervention in medically underserved areas at this stage in the game will produce subsequent savings by providing care to persons earlier in the course of their treatment curve than would otherwise be the case.

Even if that savings is not to be realized, I think it is probably generally concluded that the expansion of medical services in unserved areas is desirable. That is an area where we must be able to produce some additional costs in a system, hopefully, by producing savings somewhere else. That is clearly an area where expansion of financing and expansion of dollars in the health care delivery system ought to be achieved.

Now what about adequately served, or indeed, overserved medical areas. What about the expansion of hospital-based ambulatory services and the potential creation of new demand for services that might occur as a result of that expansion?

The strategy there, I think, is reversed. We don't simply want to expand the availability of services in those areas, although we may want to encourage ambulatory care whether it be hospital or non-hospital-based services.

The issue for us in those circumstances is that if the hospitals wish to expand their ambulatory activities for whatever reason, that must be done, as Chuck Goulet has said, there has not, so far, been any indication it has occurred, by converting the demand from inpatient to outpatient areas.

As we have said, there is no satisfactory evidence at this point that that kind of phenomenon is, in fact occurring. It needs to occur.

One would argue that one of the incentives for hospitals currently in areas like Boston to expand their ambulatory area is to create more inpatients. That is, they would like to go out and establish various kinds of ambulatory activities in order to be sure that there is a steady stream of patients going from outpatient into inpatient and thereby keeping the utilization up.

I didn't really realize the seriousness of that until an administrator of a large public urban hospital in the city of Boston, which I will not name, pointed out his realization of the enormous power he, by virtue of running an ambulance service, had. He had great leverage over where those people got delivered, and what particular time.

That produced an interesting side benefit to the hospital. It appears to me, that one of the incentives that hospitals have had is to increase their inpatient load by expanding their outpatient activities, and that is not what we want to have happen.

The result of that kind of activity is clearly the increase in total system cost in a situation where it is not clear that people are necessarily getting better or even adequate care. The problem of demand is a difficult one to understand.

We have had some experiences for example, with ambulatory non-hospital-based surgery centers in Massachusetts where they were, of course, set up on the basis of wonderful arguments that they would draw patients away from hospitals and therefore, be providing care at less cost. The reality is that they drew patients not only from hospitals, but they created new patients in the system, many who may not have required the use of that kind of service at all. To the extent that they may have drawn patients away from hospitals, they left some excess capacity in the system that cost us a lot of money to maintain. So, there were really no cost savings associated with that.

Again, the issue is the extent to which we can begin to see a conversion of inpatient demand into outpatient areas as a tradeoff for the expansion of hospital-based services.

Hospital-based ambulatory care extension should not actively be encouraged until one knows more about the actual costs of outpatient areas, particularly in terms of assessment of the impact of new allocation techniques on inpatient costs, as I indicated before. Second, the tradeoff concept, the expansion of particularly inadequately and overserved areas must clearly be tied to the reduction in inpatient capacity.

That may, in fact, be underlying the Carter administration proposal to put a cap on inpatient revenues but not to put a cap on outpatient revenues. That is putting the best face on that particular proposal. This requires hospitals, and also rate setters, by the way, to be engaged actively in planning particular Type V processes. It also requires us to begin to construct rate mechanisms for outpatient services that are tied to inpatient changes. What really has to

begin to happen is an expansion, as I have indicated, in conjunction with contraction of certain parts of the system that we think in theory will produce the kind of savings so that funds may be made available without an over-all expansion of the cost of the system. The funds will be available for appropriate expansion of services.

There is also a suggested differentiation between primary ambulatory care where perhaps it is less expensive but of equal quality to provide that in non-hospital settings and a specialized care requiring back-up services, for example, day surgery which can be used to draw away from inpatient services. That is not simply a question of hospitals expanding primary care services. It is a question of hospitals expanding ambulatory services of a like kind within all patient services. That is what I would call specialized ambulatory services.

I guess it would be appropriate to end up with some comments about national health insurance, Phase II of the Carter Control Program, as I understand it. The inadequate insurance for ambulatory care in the past has produced what, at least up until recently, has been construed as a relatively low demand for the service in contrast to inpatient services and a low price. One can argue whether outpatient has been subsidized by inpatient, but at least the price has been kept reasonably low.

If national health insurance, in whatever form, encourages ambulatory care, which most of the plans would, and the current patterns of both institutional organization and financing prevails, then what is going to happen, of course, will be an increase in both the price and overall cost of ambulatory areas.

What that suggests is the need currently for more emphasis on what I refer to as tradeoffs, the reallocation of the demand now between inpatient and outpatient. That is, the contraction of the inpatient area and the expansion of ambulatory areas concurrently. Not as a function of national health insurance because by then it will be too late to make those kinds of changes, and perhaps although this is tended to be as something of an undesirable comment, the necessity for establishing some kind of cost regulatory controls over the ambulatory areas as well.

I am a little bit surprised in that context, that the Carter administration did not so that as part of its current proposal for hospital revenue control. I suspect that if I were asked to comment, I would probably recommend that outpatient areas should be included as well as inpatient areas, because given the potential for an expansion of the demand that would come with any extension of benefits, particularly through major contenders for national health insurance dollars either now or five years from now, we are going to have the same kind of phenomenon in the outpatient area that we had with Medicare and Medicaid in inpatient services rapid growth. Having been trained in this, for a year in the Chicago school, I am not necessarily the most radical espouser of government intervention, but regulation, for the time being is probably necessary as a means of permitting the expansion of demand for services at this stage in the game, given the cost considerations and the cost constraints that currently have been placed on government and private sources of financing.

So it seems to me that we ought to be thinking about a more rational approach toward the regulation from a rate setting or cost point of view of the ambulatory areas coupled with more creative use of regulatory authority for genuine restructuring of the health delivery system, allowing more appropriate incentives.

Now that may not necessarily be the most encouraging comment to make to hospital administrators. I understand that, but, I will look at it from the other point of view and say that the increasing amount of regulation, assuming that it is done in a reasonably sensitive and rational fashion, should provide a great challenge to hospital administrators in the future.

DISCUSSION

with Paul Hanson, Charles Goulet and Stephen Weiner

CHAIRMAN WITTRUP: I am reminded after listening to this conversation yesterday and today as people keep scrambling for pieces of a pie that is certainly not growing. At the conclusion of another discussion like this, I coined for myself a little axiom. It goes like this:

Enough success will turn any noble cause into a special interest.

I commend that to you to think about on your way home.

I was a part of the committee that helped orginally think about what the subject of this symposium ought to be. I think what was in the committee's mind was whether hospital-based ambulatory care had been oversold, and whether now, instead of charging into it as a way to more adequately serve the public, hospitals ought to approach it with considerable caution. That is to say from the standpoint of a given institution's ambulatory care, is either the initiation or the expansion of institutional-based ambulatory care programs in a particular institution something that ought to be pursued on its own merit, or have we reached the stage where we ought to be becoming skeptical and cautious about that?

MR. WEINER: The tenor of my comments, would support the conclusion that one ought to be fairly cautious both from the point of view of hospital interests and from the point of view of the regulatory system in which the hospital is going to be operating. I made some assumptions about what the motivation would be on the part of the hospitals to engage in that kind of expansion. If, as I suggested, one possible motivation is the shifting of inpatient expenses into the outpatient area, that might not work in the long run if there is an effort to keep up inpatient utilization. In some systems, New York's, for example, that may be desirable, depending on what utilization review has to say about it, but in the long run, again I suspect, if there are sufficient pressures on the system to contract inpatient services, that kind of device for maintaining levels of utilization may not really work very well.

If the motivation is, if you will, somewhat more altruistic from the point of view that you can really be sure that services are being provided in a community where services are not currently being provided, one has to be fairly careful about the organizational structure that is established for providing the services.

That was my distinction, between primary and specialized ambulatory care. With specialized it would seem that it would be an appropriate hospital-based activity, probably best dealt with on a free standing basis with some backup support available from the hospital operation, but not directly as a hospital service itself.

MR. GOULET: My concern is that the reliance upon the traditional doctor-workshop concept providing the specialized diagnostic and therapeutic services to solo practicing physicians continues to be the order of the day with very little thought being given to the true role of the hospital in using its capacity to organize, to accumulate capital, to allocate resources and to address broad issues of personal health care services.

MEMBER: Mr. Weiner, I hear you saying that our approach to ambulatory care should be based on whether or not it is cost effective from a total cost point of view. Yet, Mr. Hanson has talked about need.

Are those two things incompatible in any sense? Do we really know what the cost-benefit relationships are between inpatient and outpatient?

MR. WEINER: I don't see any conflict between need and, if you will, cost effectiveness. Very often there is an attempt by someone to rhetorically construct some differentiation between those two. There is, in many areas, fully the need to expand services, and that is going to cost more money. One would hope that whenever that expansion of services takes place, it will be in the most cost effective fashion. It is not desirable to simply expand services in a really profligate fashion.

I don't see any distinction. I think need and cost effectiveness really are interlinked to the way the health delivery system is going to be operated.

Do we have a handle on the cost effectiveness of inpatient versus outpatient is probably the question that you were asking. I was trying to say in my comments quite directly that I don't think we do at this point. I think we all proceed from a set of assumptions and any analytic backup that we have to prove any of

these assertions is not what one would consider as very strong and vigorous intellectual muster right now.

Let me just make one other point that I occasionally make, and that is the importance of beginning to distinguish between need and demand of services. Having been here for a year, the demand is unlimited. The question really is how you can begin to get a handle on what need is as opposed to demand. In that, we have only begun to scratch the surface.

MEMBER: On the issue of home care, there seems to be a small but very vocal group of people who see this as a great alternative to inpatient care and somewhat related to the ambulatory care system. Yet, Chuck Goulet was able to point out that there is no evidence that there is a benefit from this. Rochester, New York, is the particular city in the country that is pointed to as having a model home care program that saves all kinds of money in inpatient care.

I was wondering if Paul Hanson has had any experience to refute or support that.

MR. HANSON: The home care situation is significant in Rochester because it does produce an alternative to both the ambulatory setting in an office or a hospital as well as the inpatient system. There is a cost benefit that has been described. Whether or not that is irrefutable data and economically sound, I think we will know in some future date, not too far down the pike. In New York, home care became so successful that two weeks ago our friendly State Health Department came down with a set of regulations you wouldn't believe. We are going to manage the home care system under a set of regulations that are going to increase the cost tremendously right now. Up to this point I think you are right on target that the home care has been an alternative, whether it will continue to be in New York is in doubt.

MR. WEINER: It seems to me that the critical issue that we are now beginning to address is how to take regulatory authorities and knit them together in a mutually reinforcing fashion that will produce a desirable model of a system.

We have achieved at least one level of doing that which is that we now have adequate regulatory authority in the State to begin to jog the system in the State with our budget review activities and certificate-of-need program and linkage now with planning and utilization review.

The issue we have not addressed is really one of competence. I do not take the position that I have any competence to make decisions as to what the design of the delivery system should look like in ten years. I am a rate setter. That is a very limited responsibility in reality.

We spent a lot of our effort last year as we were trying to design the budget review legislation to really convince people that there is a more appropriate process in the system, to begin address those kinds of issues. I am speaking specifically of 93-641 in that context, the consumer provider model, the use of what one hopes will be eventually a rather integrated system to begin to look at both the needs and the appropriate structures to produce those needs. It is from my point of view, the preferable way to go. I suspect that I would be accused of being naive in placing a lot of faith in the ultimate effectiveness of that system.

In order for it to work, though, we are very firmly of the view that it has to be given some regulatory underpinnings. A major part of our agenda over the next three to five years will be to link the planning process with the regulatory authorities that currently exist, so that there would be, in fact, an authoritative way to begin to produce that kind of redistribution.

MEMBER: Paul Hanson placed so much importance on training the physician. I am a little curious about how you train those three hundred-odd physicians in medical economics.

MR. HANSON: Now on any medical staff, you know the percentage that probably will admit 90% of the patients to your hospital. On our staff of 250, we have about 110 physicians that admit 90% of our patients.

We started out in our program with the chiefs and medical staff officers. We began with all-day sessions with the medical staff. We used different segments of the medical staff because we did it on their days off at their request. We did it consistently over a period of two to three years. It took a long time to get the reimbursement concept in the minds of a physician because that is a very difficult thing for us to understand, much less the physicians.

For them to take their own time was the intriguing part. They then moved on to encourage other members of their staff, and I would say today beyond the chiefs of our staff of our departments, you could probably pick 30 medical staff members who have an intelligent speaking knowledge of medical reimbursement in Genesee.

MEMBER: I would like to ask Mr. Weiner a question. I gather that in the State of Massachusetts there is a Rate Setting Commission which you head. Certificate-of-need, therefore, is not under your Commission. Where does it rest in Massachusetts?

MR. WEINER: The certificate-of-need program is administered by the Public Health Department. Actually the Certificates are granted by a body called the Public Health Council.

MEMBER: Then it is under a designated public health, Director of Health for the State, or something?

MR. WEINER: That is right, the Commissioner of Public Health is the Chairman of the Council.

MEMBER: In New York State, as I understand it, that is all under one man. Is that correct?

MR. HANSON: Yes. At the moment it is Dr. Cahill, although he is not the Commissioner of Health.

MEMBER: I refer to these facts because I am not sure whether this had anything to do with the way the legislation was set up in Massachusetts, but I think there is a lesson to be learned. When you establish one person it is very simple for the legislature and the governor to pass legislation and say: "You will do all of this."

One man makes all the decisions. I notice Mr. Weiner is saying he is not quite sure what he thinks the system should be and hopefully, his counterpart over at the Department of Health shares that conviction, so that it can evolve. Therefore, the rate setting is not solely intended to support a certificate-of-need program.

MR. WEINER: The structure is even a bit more complex than that. We have a secretary of Human Services who is in the Cabinet structure. He does not have line responsibility for any of his programs, but he has coordinating and supervisory responsibility. There is a Commissioner of Public Health, a Public Health Council which consists of 9 members of which the Commissioner is the chairman and the Rate Setting Commission which has three members, all of us full-time currently.

We have both Medicaid responsibilities, general charges responsibilities and budget review responsibiliy.

In large part New York has had the weirdest experience, because Blue Cross has been tied to Medicaid. The governor, of course, has been rather uptight about the Medicaid budget, and therefore, a lot of the efforts to change the system in New York will be a function strictly of Medicaid budget concerns.

In Massachusetts, we do not have the tie-in between Blue Cross and Medicaid which I think made the beginning of the process easier. Rather than try to tie all the changes in the regulatory system to the Medicaid budget, we went the route of going after hospital control independent of Medicaid. So that we would, in fact, have the ability overall, to dampen the increases in the system that would have secondary benefits to the Medicaid program, but would not use the Medicaid program as a primary regulatory device in the system. That makes an enormous difference in the way one approaches the system changes we are dealing with. Ours, of course, is more rational.

CHAIRMAN WITTRUP: Some of you may remember a fellow named Charlie Wilson who was a rather vocal man, and who was the Eisenhower Secretary of Defense who had previously been President of General Motors. He is reputed to have been asked what his biggest challenge was during the period he was President of General Motors. He was reputed to have answered that his biggest problem was to prevent what he called unnecessary concentrations of stupidity. If you think about that, you can understand why that would be a problem because with a single corporation like that, the farther up the system a bonehead idea goes, the greater damage that it does.

I am reminded that oftentimes in the context of the discussions we can't decide whether we ought to have a single regulatory agency for health systems, or whether we ought to keep it in its currently spreadout, rather than confused, fashion.

I would like to change the subject a little bit, though, and say that I started this discussion by saying that perhaps the question that the Planning Committee had in mind when they set up this program was a little oversimplified.

I got the impression yesterday that ambulatory care is not a single subject. Where ambulatory care is, in effect, the center of the system, the base of the system, as it would be in Kaiser or other HMOs, that is one kind of situation where you deal with ambulatory care. Where it is peripheral to the basic system, as I would gather it is for most hospitals in the country, that is a very different question. That poses a whole series of different questions.

MR. GOULET: The historical role of the hospital and the payer has been to concentrate on the high cost

inpatient service without regard to the integration of primary care. I was suggesting that we may be at the moment where we can couple the pre-payment mechanism with efforts to achieve some level of integration in and around the hospital. So that the issues of primary care, which I tend to think are still largely unanswered in urban and rural America, are addressed. We haven't found a way that is legal in our democratic society to redistribute health manpower. I am suggesting that it is up to the hospital and what the hospital represents in terms of governance, administration and medical expertise to look at that and to determine on a corporate basis, what, in fact, is the role of the institution. What I am suggesting is that the role or the mission of the institution is somewhat different than what you and I have known it to be historically.

MR. BUGBEE: I would like to ask Paul Hanson whether perhaps his medical staff was made somewhat more receptive by the aggressive organization of pre-paid group practice in Rochester.

MR. HANSON: That is a correct statement. But, you have got to go back six to seven years when the prepaid group practice idea came out, especially the spark that Blue Cross sent. The RHN plan or the Network was after that, but they did know it was coming, and fought it, but didn't quite understand it. It is just like your own hospital. They don't understand it, and they are going to fight it until they understand it. Now all of a sudden they have 100 physicians ready to go this July on the Independent Practice Association.

MR. EV JOHNSON: I would like to ask Chuck Goulet this question.

Taking the position that you just stated, how are Blue Cross and Blue Shield going to move on that at all until they become one corporate entity?

MR. GOULET: I agree with you that there has to be a continuing movement to bring Blue Cross and Blue Shield together because we are dealing, at least in some states, with arbitrary divisions between Blue Cross and Blue Shield benefits. You can spend half your life trying to sort those out, and if you have to have separate rate approval, then it just drives you up to the wall because you don't know whether the radiologist is going to bill through the hospital or independently for this group of subscribers.

I agree totally with what you are saying. I can also tell you that there is no secret that there is a broad based committee nationally headed by Mr. McConnell from Kentucky that is taking a look at the two national associations.

Now if I were to tell you that that committee is talking about merger, I would be run right out of the plan, but they are looking at issues having to do with the resolution of these arbitrary divisions between Shield and Cross. It has been moved along, I should add, by the fact that the Federal Trade Commission and others have been taking a hard look at the control and governance of Shield Plans which traditionally, as you know, have been sponsored by medical societies.

MR. ODIN ANDERSON: Chuck, are there any practical consequences yet of the mergers?

MR. GOULET: I don't know as I can comment on that because the reasons for bringing the plans together were different situations in different parts of the country.

In New York they were brought together because the Shield plan was literally going down and Cross came in to salvage it. Now in our own case, the reason for the merger was that we had a very antiquated reserve requirement on Shield. If we were to expand in the physician service area, the non-institutional service area, we couldn't possibly have created the financial base to meet the statutory requirements. So we had to move and merge the reserves in an effort to get that financial base to hold that movement.

In Michigan, I think it was a recognition that a single management with the auto industry dominating the plans business could result in economies in the administration of the plan. The motivation does vary along with the consequences. I think it is fair to say that the results achieved have been beneficial to the system.

MEMBER: As you get big government or regional government and insurance companies start to coalesce, at least in terms of their administration and the types of plans that they administer, do you think this foreshadows a coalescence of hospitals into sort of regional corporate bodies or something like that as opposed to the independent, free standing types of things we have known?

MR. WEINER: There were two issues from the point of view of cost savings associated with mergers. One is whether the mergers, in fact, produce a contraction in the number of beds or services. We have really not seen that occur yet.

The other data phenomenon that I have seen in mergers has been either the situation where they wished to consolidate physically, they want to build very fancy new buildings, and that costs us more money.

CHAIRMAN WITTRUP: I believe that what consolidation is, from the hospital's point of view, is a way to develop a stronger power base to deal with the Steve Weiners of this world. That is what fundamentally motivates us.

Now to the extent that they are successful, what it means is that, in one way or another, they will get more money out of the system collectively than they would have gotten out of the system individually.

The economics of this business don't work like they do in other forms of enterprise. The economic motivation of the non-profit enterprise is to maximize the level of expenditure, and doing that as a group gives you more strength from which to proceed than doing it individually for some very simple reasons.

One is that you can afford better lawyers and better accountants if you go together. The other thing is that you expand your constituency for a single place once you have merged. So that instead of regulators having the opportunity to sort of pick them off one at a time, they have to take on the whole community. Once you get that kind of a base, get your local Representatives and Senators to go down and file Bills, suggesting that they abolish the position of the Chairman of the Rate Setting Commission.

I believe that these mergers have to be understood mainly as political reactions to regulations rather than anybody's motivation to try to cut down some beds or share some services.

MEMBER: I guess an even more fundamental question has to do with whether or not the rate regulating process apriori is effective in controlling prices.

CHAIRMAN WITTRUP: Fellows, there is a professor at MIT who points out that in complex social systems most remedies are apt to have the opposite effect for which they were designed. The State Senator in Massachusetts who chairs the key committee, came to the hospital meetings the year they were planning the first rate bill, and he said, "Look, let's not kid each other. This is going to increase the cost of medical care in this Commonwealth, right? Every regulatory program that was ever adopted has had that result. There is no reason to believe that this one will be any different, but we are under a lot of pressure to do something, and we are going to do it no matter what you say."

There was a reasonably short meeting and an education for everybody. But I think that still doesn't mean that in the over-all picture, there isn't a constructive force towards some broader goal than immediate reduction in expenditure.

I want to thank our speakers. I think it has been a good program.

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