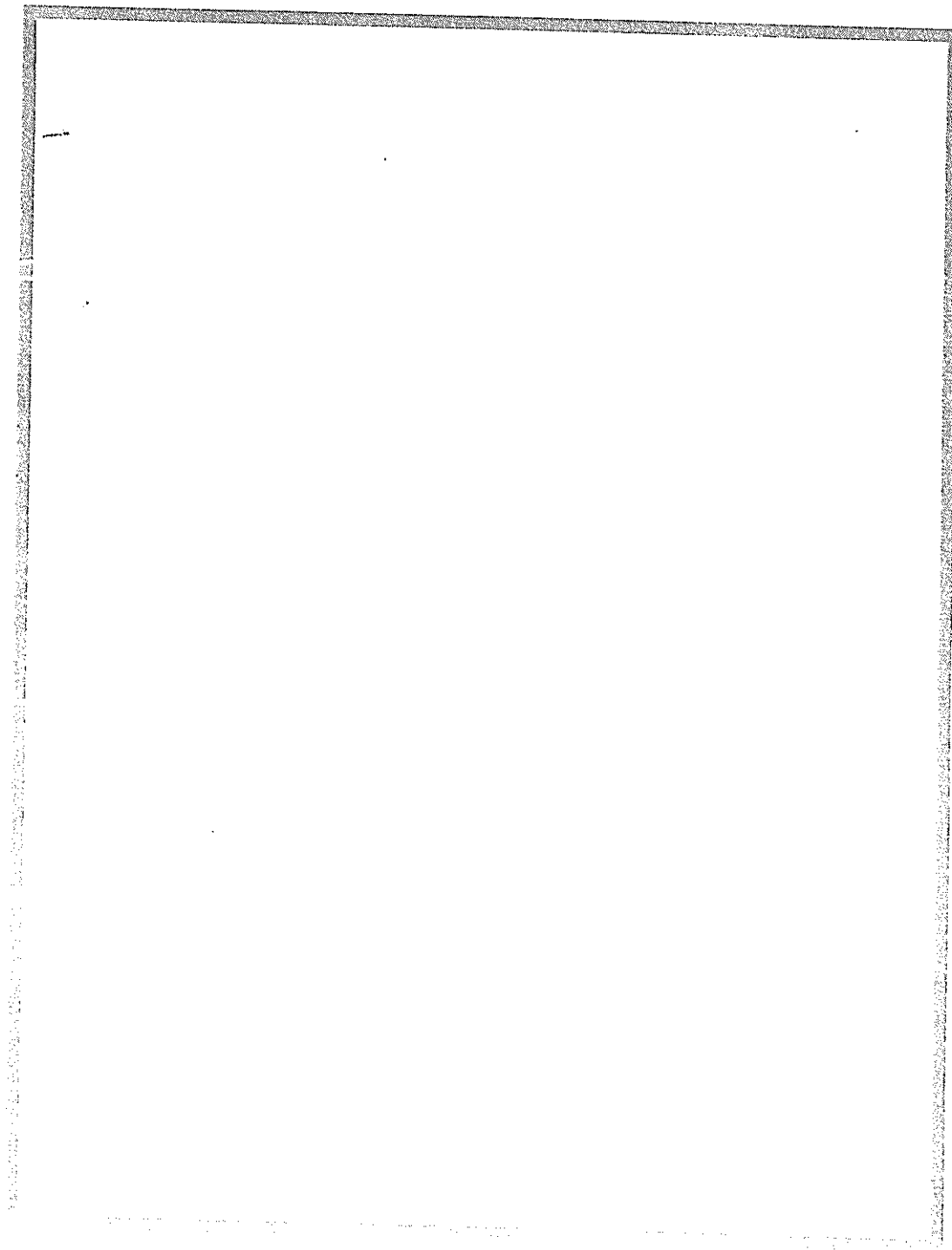


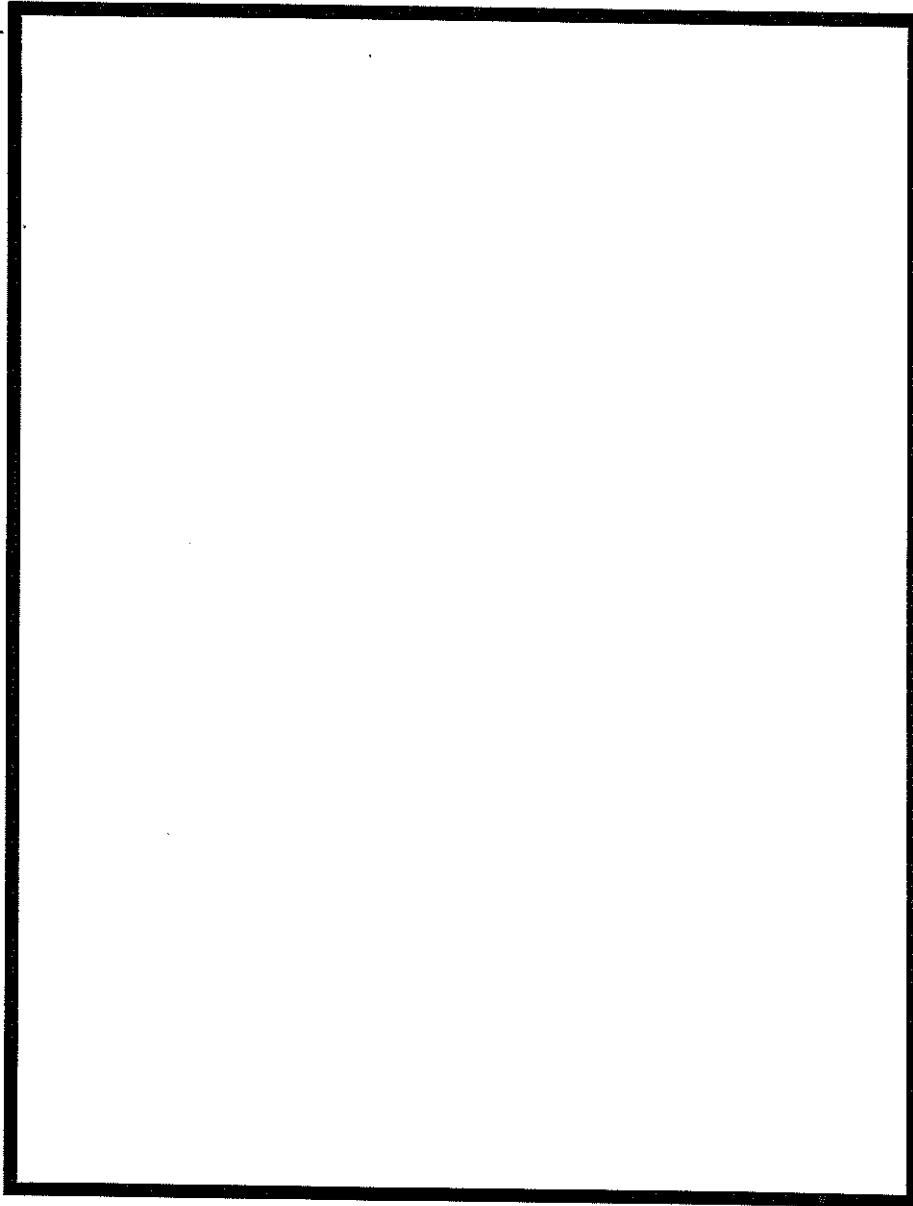
# Public Control and Hospital Operations



*Proceedings of the Fourteenth Annual Symposium on Hospital Affairs*  
*May 1972*

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

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## INTRODUCTION

### **Public Control and Hospital Operations**

The purpose of the Annual Symposium is to bring together the student, the professor, the administrator, and the planner and provider of health services to define and analyze a particular issue which is apropos, timely and important to the present state of the delivery of the health services.

Today, the consumer of health care services is demanding more from the hospital and the physician for less money while in an era of rising costs. Today, the doctor, the hospital, the provider of health services is being held publicly accountable for the quality of service delivered and the cost incurred by the patient.

The demand for public accountability and public disclosure of finances and its relation to quality has brought with it the need for control-

control of supply and demand, control of quality and quantity of care, through such mechanisms as rate review, utilization review, the approval for capital expansion through such means as the Hill-Burton state plans and area-wide comprehensive planning and those controls such as insurance benefits.

Among the questions addressed by speakers at the Symposium are: If more controls are to be proposed, what will the mechanism for control be, what form will the controls assume, will controls achieve the desired effect? Who will enforce controls once they may be established?

The papers and discussion reported in these proceedings will have continuing pertinence to the ongoing discussion and evolution of controls in the health field.

The Fourteenth Annual Symposium on Hospital Affairs conducted by the Center for Health Administration Studies, Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on May 5 and 6, 1972. Chairman for this Symposium was Joel May, Director of the Graduate Program in Hospital Administration; Assistant Director of the Center for Health Administration Studies; Lecturer, Graduate School of Business, University of Chicago.

These symposia explore current problems in the health field looking at present trends and anticipating the future needs. Because the subject of this Symposium, "Public Control and Hospital Operations," was one of such concern and importance, and, because of the interest demonstrated by those attending, the transcripts and papers presented have been published for distribution.

## **Reimbursement: Past, Present, and Future**

**HAROLD HINDERER**

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CHAIRMAN MAY: Every year when we try to choose a topic for this symposium we bring together our faculty to try to identify an area of concern which will be important by the time May 1 rolls around. We did this in the late fall last year, and sometimes it is fairly difficult to predict what will be important. I have a feeling that this year we played it safe, in the sense that controls have been with us for some time and will continue to be with us for some time; so we weren't really risking very much in choosing the subject.

I do think, however, that with the kind of developments we are seeing more and more controls, more and more interest in controls, more and more responsiveness to controls, is going to be required.

I thought what I would do just by way of introducing the session is to talk a little bit about controls as such in the health care field, and then leave it to our speakers for the rest of the day and a half to talk about three areas in which controls are particularly ubiquitous.

It seems to me that control, in so far as you and I see it from our operating settings, is really the equivalent of any kind of intervention by anybody else for the purpose of modifying our behavior. That is a pretty broad definition, but essentially that is what a control is. Anything that somebody lays on us for the purpose of causing us to do something that we otherwise wouldn't have done, or preventing us from doing something we otherwise would have done, is a control.

Many approaches to regulation or control of our industry have been tried, and many more have been proposed. Some of these approaches have had the ostensible if not real purpose of bringing rationality to the health care system. The Hill-Burton state plans which were required since 1946 are essentially an effort to bring rationality to the system. Area-wide comprehensive planning is another kind of mechanism for control which is designed to create rationality.

Another category of controls that we have

seen are those which are designed to provide incentives to cause us to perform more effectively or more desirably in our operating settings: Insurance benefit structures are an example of this, grants and subsidies for specialized services, rewards for doing certain things are incentives which cause us to perform "better."

Then there are sort of true controls, which serve to limit the range of alternatives that we have. Rate review, utilization review, prior approval for capital expansion—the purpose of these is to reduce our alternatives to a set which society believes we ought to be dealing with, to prevent us from doing undesirable things.

What we hope to do over the next day and a half is to examine some current developments in this area in the context of their effect on our day-to-day operations, to delineate the major issues for us which are raised, and to understand and deal with them in operating settings.

In order to help us to think about the rather heterogeneous range of topics that we will be covering in the next couple of days, I came up with two different classification schemes, one or both of which might be useful in listening to the speakers and understanding what they have to say and in carrying away something that will be useful.

The first has to do with sort of an economist's view of controls and what they are designed to accomplish or what facet they are operating on. Essentially, controls can be classified as being controls on the demand, or what the people want to get from the system, what quantity and at what price, or controls on supply, essentially what we are providing.

Examples of controls on demand which we have seen are the scope and nature of insurance benefits, the number of people covered, the kinds of new coverages which are being proposed and developed, all of which serve to change behavior of the patients as they are coming to us. The large number of semi-private beds in hospitals is an example of control on demand which has resulted in changes in behavior. The Blue Cross was reimbursing, and so on, so we provided it.

The structure of benefits—for example, outpatient versus inpatient benefits—If society wants us to start providing more care on an outpatient basis and less on an inpatient basis, one way this can be accomplished is to encourage people to ask for outpatient care and use it by providing benefits for it and reducing benefits on the inpatient side.

There are incentives for the patient to economize in his use, like coinsurance, deductibles. There are incentives for the physician to economize in his use of our services, like utilization review and programs such as HASP, Hospital Administration Surveillance Program, in Illinois.

Then there is a whole different set of controls which operate on the supply side. Controls on the pricing systems, such as rate reviews. Controls on the quantity of services delivered to various population groups, like the regulations which the Secretary promulgated on April 18—the 5 percent reasonable level.

There are controls on costs and on volume which we are familiar with; and there are controls on construction; controls on competition that take the form of licensing, certificate of need, and franchising. Many of these we will be looking at over the next couple of days.

So, when a control is proposed, or when a mechanism for control is proposed, one way to examine it is to look at it as to whether it affects the demand or the supply side of what we are up to, whether it will cause what you do with response to demand to be different, or whether it will cause the demand that you are seeing in your hospital to change.

Another kind of classification scheme is really an outcome classification, or the desirability of the outcome resulting from the control. Controls are exercised on many, many dimensions of what we are doing. They are exercised on cost, on volume, on range or services, on the quality, on access, and so on.

I put together a little table. This deals with

cost and volume only. If these were the only two dimensions we were dealing with, presumably as a result of controls you can get less or the same or more volume at least, or the same or more cost. That is all the possible outcomes. To get less volume at less cost is one possible goal of a control mechanism, and it might be desirable or undesirable; it depends. To get the same volume at the same cost, or to get more volume at more cost, all of these we can identify control mechanisms which presently exist that are designed to accomplish those outcomes.

Whether or not the outcome is good depends upon how you look at the various variables. Clearly, you would not want to develop a control mechanism that would produce less volume at the same cost or more volume at the same cost or the same volume at more cost, but you might develop a control scheme to develop the same volume at less cost, more volume at less cost, or more volume at the same cost.

As you in your operating settings look at controls, this is a scheme you can look at. Essentially only three of the nine possibilities are excluded *a priori*. Any one of the rest might be the goal of a control system. And the control system is good, bad or indifferent. Your response to it is positive, negative or neutral, depending upon how you view the outcome matrix.

I could go on talking about this a long time, but the point is I am trying to give you a pair of schemes. I am sure you could each come up with one of your own, after listening to the speeches over the next two days.

The first subject we are going to cover, the first area of control, is controls which are inherent in the reimbursement process. Following that we are going to look at controls which are inherent in the prospective planning for the organization via budgeting, and finally tomorrow morning we will look at controls which are the sort of controls on competition or controls on construction which are inherent in the certification of need or franchising or licensure process.

The first speaker is Harold Hinderer, who is Controller of the Daughters of Charity Shared Services, St. Louis, Missouri, and a faculty member at Washington University. I have heard Harold speak many times, and I think he is one of the most thoughtful, best informed and most broadly oriented accountant I have ever met.

		VOLUME		
		More	Same	Less
C O S T	More	++	+0	+ -
	Same	0+	00	0 -
	Less	-+	-0	- -

MR. HAROLD HINDERER: I promised Joel that I would not go into a long, long dissertation, because there is a limit to how much you the audience can take. In addition, it is probable that we will get more out of the questions and answers than from the formal presentation. Please don't hesitate at all to try to keep this informal, to try to keep the session lively. I am very willing to have you raise questions during the discussion at any time. As I said, I promised Joel not to be lengthy. Time is of the essence.

One little story about time has to do with when I was with the Catholic Hospital Association. Father Flanagan and the late Ray Kneifl went to Montreal for the dedication of a new hospital. The Medical Director of the hospital met them at the airport. It is interesting that this Medical Director was not Catholic, which was strange in Montreal, especially in a Catholic hospital. In addition to that, he had never been to a mass or a Catholic service or liturgical worship.

He made it a point to see that every wish of Father Flanagan and Ray Kneifl was taken care of. They got to the hospital and the Sister Superior met them at the door. The first thing she said was, "Father, you are to say mass tomorrow morning. We want you to give a short sermon, but you must be finished at 9:45 because his Grace the Archbishop is coming for the dedication. Please, 9:45!"

That evening after returning from dinner Father went to his room, and found a bottle of Coca-Cola, a few cookies, and note, "Please, Father, 9:45!"

The next morning at breakfast the Sister came in and said, "Don't forget, Father, 9:45, but I do want a sermon."

Father went back into the sacristy to put on his vestments and found another note. It said, "Please, 9:45!"

Ray and the doctor went into the chapel. Doctor was fascinated by all the statues and pictures on the walls. Ray explained what the stations of the cross were, who the statues depicted, etc. Finally Father Flanagan come out. This was in the old days when the mass was in Latin. He got to the foot of the altar and started saying the mass, and Doctor asked, "Ray, what does that mean?" He explained it to him. "What does 'Dominus vobiscum' mean?" Ray explained it to him. When Father came to the Gospel, there was Sister Superior sitting in the back looking at her watch. Just to reassure her, Father took his watch off and put it on the pulpit. Doctor

said, "Ray, what does that mean?" Ray replied, "It doesn't mean a damn thing." So you know what you are in for.

Although this paper is entitled "Reimbursement: Past, Present and Future," there is little to be gained from looking at the past except to understand better the present. Likewise, the better our understanding of the present, the better the chances of our being able to play a meaningful role in the shaping of the future.

There has been so much written about the history of reimbursement that it would be presumptuous on my part to think that I could make any truly meaningful addition. For those of you who wish to pursue the development of reimbursement, I would recommend, among others, the following publications: Somers & Somers, *Medicare and the Hospitals* (one of the authors, Anne Somers, is with us); Duke University's Report of the 1968 National Forum on Hospital and Health Affairs, entitled *Hospital Reimbursement—Methods and Consequences*; the American Hospital Association's 1963 Report of the Task Force on Principles of Payment for Hospital Care; the Social Security Administration's Office of Research and Statistics Research Report No. 26, *Reimbursement Incentives for Hospital and Medical Care*.

In looking at reimbursement today and in trying to anticipate the future, it would seem that attention should be focused on Medicare. While Blue Cross in many areas is more significant volume-wise, there are few who doubt that what takes place with regard to Medicare today is setting the universal pattern for tomorrow.

Although there is by no means unanimous agreement as to the adequacy of the Medicare reimbursement formula, there are several areas about which there is widespread concern.

Unfortunately, the generally agreed upon inadequacies can be traced, in part at least, to deficiencies in the Principles of Payment for Hospital Care. These Principles had served as the foundation upon which cost reimbursement formulas had been built.

The major areas of concern are: (1) The cost of rendering care to those who are unable to pay; (2) working capital needs, and (3) depreciation.

The refusal to bear a proportionate share of the costs of caring for those unable to pay was based to some degree on Principle 2.304 which stated: "Bad debts, the unpaid costs of care of the indigent and medically indigent, and cour-



tesy allowances are deductions from earned income and should not be included in reimbursable cost."

The Comment which accompanied this Principle stated in part: "It is apparent, however, the net operating deficits resulting from the foregoing factors must somehow be covered if essential services are to be maintained; therefore, it may be appropriate that a reimbursement formula developed under the terms and provisions of Principle 1.100 give recognition to this fact."

Unfortunately for the hospitals, existing reimbursement formulas, with few exceptions, did not give specific recognition to this financial need. Thus, precedent had been set.

At the start of Medicare, the problem of the cost of care to indigent was visualized as but a relatively temporary problem which would dissipate as Title XIX became operational. As we know, there are many states in which the problem remains and may, indeed, be getting worse.

In a time of growth, especially one accompanied by a rather high rate of inflation, significant additions to working capital are essential. Again, the Principles of Payment for Hospital Care gave no specific recognition to this financial need of the hospital. It is true that the need for additional working capital could be encompassed by Principle 1.100, which read, "The amount and method of payment to hospitals should be such as (1) to pay fairly and adequately for services purchased, (2) to maintain essential services, and (3) to encourage the development of higher standards of service to meet the needs of the community."

The comment which accompanied this Principle did not make reference to working capital needs except in the same vague language of the Principle itself. Again, Blue Cross reimbursement formulas did not give specific recognition to this vital financial need.

It is entirely possible that the working capital squeeze may be the most serious financial problem facing hospitals today. Since the required working capital is essential to continued operation even in the relatively short run, providing it is a matter of the highest priority. All too frequently, the only available source of these funds is the cash which results from the reimbursement for depreciation. The resulting "non-funding of depreciation" holds frightening prospects for the future.

Traditionally, most hospital trustees have

considered their responsibility one primarily of stewardship. The preserving of the assets entrusted to their care has been second only to the safeguarding of lives. With the continuing decline in the purchasing power of the dollar, it is impossible to preserve plant capital when the hospital is reimbursed only for depreciation computed on historical cost.

The aforementioned Principle 1.100 could easily be interpreted as recognizing the necessity for some amount in excess of historical depreciation as being a financial requirement of the hospital. However, the necessity to offset the erosive effects of inflation was not addressed directly. With a very few exceptions, the existing cost reimbursement formulas were based on historical depreciation or a percentage of expense in lieu thereof.

The failure of the American Hospital Association to identify these so-called non-accounting costs in its Principles of Payment for Hospital Care should not be interpreted as an unawareness of their being true financial needs of the hospital. The Report of the Task Force on Principles of Payment for Hospital Care, which was sent to the House of Delegates on July 7, 1963, gives unmistakable evidence that the Principles were recognized as being deficient in the areas to which reference has been made. It would be conjecture on my part to give an explanation of why the indicated clarifications were not made. Suffice it to say, they were not.

In spite of the failure to give explicit recognition to these various financial needs, implicit recognition was present in most reimbursement formulas through the inclusion of a plus factor. Thus it was that the "accounting" costs were recognized specifically and the "non-accounting" costs acknowledged but not identified.

When the Social Security Administration issued Principles of Reimbursement for Provider Costs in May 1966, the hospitals looked upon Principle 1-11 as merely the Medicare program's adoption of an accepted practice. This Principle, entitled Allowance in Lieu of Specific Recognition of Other Costs, and its related comments, leaves no doubt about its being comparable to the plus factor in then existing reimbursement formulas. The Comment states in part: "It is the established practice of a significant number of large third-party

purchasers to include in payment for costs of services a factor in the form of an allowance to cover various elements not specifically recognized or not precisely measured."

One can only speculate about what the reimbursement picture would be today had the 2 percent not been included in the original Principles of Reimbursement for Provider Costs. Would the hospitals have entered the program if they knew that there was no way in which their financial needs could be met? Or would the so-called "non-accounting" costs have been identified, and acceptable methods for their measurement developed?

Regardless of what might have been, the fact is that the hospitals did accept the proposed Principles in good faith. When the 2 percent was eliminated, the hospitals were, for the most part, too deeply committed to the program and too concerned about the aged to give serious thought to their withdrawing.

As long as the hospital has an ample base of patients from whom it can obtain the resources to meet its needs, there probably won't be a noticeable increase in the demands for adequate reimbursement by Medicare. But as more and more patients have their care paid for under a Medicare type reimbursement formula, the financial position of the hospitals will become critical and the demands for adequate reimbursement will reflect the concern for the very survival of the voluntary system.

Assuming that the inadequacies of reimbursement will be rectified, a look into the future is possible by studying the actions of those who have in the past, do now, and will in the future, set public policy. Just a brief reading of the Report of the Committee on Ways and Means on H.R. 1 should give strong indication of what we can expect reimbursement to be in the future.

There are three sections of H.R. 1 which have a direct bearing on what the shape of reimbursement may be in the future. Under present law, the Secretary of Health, Education and Welfare has the authority to conduct experiments in reimbursement. The final paragraph of Section 222 (a) of the proposed law reads:

The Secretary of Health, Education and Welfare, directly or through contracts with public or private agencies or organizations, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, extended care facilities, and other providers of services for care and services provided by them under Title

XVIII of the Social Security Act and under state plans approved under Titles XIX and V of such Act, including alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement.

So, we can see that H.R. 1 has set the stage for prospective reimbursement. It has, in effect, mandated that this will be the reimbursement system for the future. The Committee's explanation of this section leaves little doubt that prospective reimbursement will be of more than just passing concern for hospitals.

It is interesting to note that the Committee is deeply concerned about the real possibility of a provider's trading quality for incentive dollars. The report states:

Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established. The development of adequate and widely-agreed-upon measures of quality of care will clearly be needed to provide that assurance and should be immediately developed by the Department.

So, here again the Committee is saying to HEW, "It is time for you to come up with standards of quality to insure that the incentive to trade off quality for dollars will be precluded."

Quite obviously, any consideration of prospective reimbursement is predicated on the existence of a meaningful budgeting process. Section 234 would require that each provider have an annual operating budget and a capital budget projected three years into the future. Thus, again we see positive action being taken to lay the foundation for prospective reimbursement. What is not mentioned, however, is the increased sophistication in accounting procedures that prospective reimbursement will demand. A clearly defined methodology for the determination of the fixed and variable components of each element of expense must be developed if prospective reimbursement is to be an equitable payment mechanism.

I mentioned to Dennis that one thing H.R. 1 does is to guarantee us accountants job security. Just like the public accountants, whenever a new, complicated tax bill is introduced, they

are there to support it. The more complicated it is, the better they like it.

The Committee has made clear its concern about providers' inefficiencies in operations and the rendering of service in luxury accommodations. On the other hand, the right of local citizens to choose unusually expensive service would not be denied. Section 223 is, without a doubt, some of the most interesting reading available.

The following is a direct quote from the Committee report:

Your Committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. Your Committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

Where the high costs do in fact flow from the provision of services in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not the Committee's view that if patients desire unusually expensive service they should be denied the service. However, it is unreasonable for Medicare or Medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly, when the high costs flow from inefficiency in the delivery of needed health care services, the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy, should be encouraged to perform efficiently and, when they fail to do so, should expect to suffer the financial consequences. Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

These are pretty strong words, and people have said them before. When we have Mr. Mills and the Ways and Means Committee saying them, I think we pay attention. I remember from my Jewish friends a quotation from the Torah that I have never forgotten: "When a person

calls you an ass, pay him no heed. But when many people call you an ass, and often, best you buy yourself a saddle." So, I have been to the tack shop. Mr. Mills has made a believer out of me.

The Committee proposes that reimbursement be limited by the imposing of a ceiling based generally on the average cost of the particular service for a group of hospitals in an area. The Report makes specific mention of the costs of the "hotel" services as being likely candidates for initial control. It also mentions that attention might be given to laundry costs, medical record costs and administrative costs within the relatively near future.

It is interesting to note that the Committee makes mention only of non-revenue producing areas. Clearly, comparisons based on direct costs alone would not be valid. Instead, it would be necessary to compare functional costs. The reciprocal cost allocation inherent in the determination of the costs of mutual service areas will require the development of new methods of cost determination. Those employed today will not suffice.

What is different about the proposed limitations on cost reimbursement is that, generally speaking, the hospital would be permitted to charge the patient for the difference between its actual cost and the limited reimbursement to which it would be entitled. Two conditions, however, have to be met if the hospital were to levy a charge against the patient. The conditions are:

1. The Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this title on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under this title by particular providers of services in the area in which such items or services are furnished.

2. The provider of services has identified such charges to such individual or other person, in such manner as the Secretary may prescribe, as charges to meet costs in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title.

So, the Secretary must make public notice. Secondly, the institution itself that is going to charge an additional amount must identify those charges to the patient before admission, explaining that these charges represent costs in excess of what the Secretary has determined to be necessary, certainly an incentive.

Clearly, it is the intent of the Committee that

to some extent, at least, hospitals would enter into the competition of the market place and be subject to the pressures of the consumer who, theoretically, would be able to evaluate alternative sources of service at least from the viewpoint of price. Remember, the Committee has recognized the need to assure quality.

The insulation of the hospital from the laws of the market place has been cited more often than any other factor for all that is wrong with the hospital system as it presently exists. Quite representative of this line of reasoning is the following passage taken from the Report of the Task Force on Principles of Payment for Hospital Care. It is entitled, "The 'Market Place' Concept:"

In the ordinary commercial market place, the price of an item has a direct relationship to the willingness of a customer to buy the commodity. In the Blue Cross-hospital economy, this relationship of the price of care to demand by the patient does not exist. The decisions as to whether to be hospitalized, where to be hospitalized, how long to be hospitalized, and which services to receive while hospitalized, are generally not made by the patient but rather by the physician, whose judgment will not be governed by economic considerations. Moreover, in the case of a Blue Cross subscriber, the volume and cost of the hospital care he receives usually do not have significant impact on his own pocketbook, except in ways that seem well removed from his current problems. As a matter of fact, with a growing percentage of Blue Cross dues paid by management under collective bargaining agreements, or by union welfare funds, the cost of an individual's own hospitalization may become of virtually no importance to him.

Given this situation in which spending decisions are being made by someone other than the patient, and payment is being guaranteed by a third party, in what way can a market place concept of pricing be applied reasonably to the hospital economy? Clearly some forces, in lieu of the market, have to act as a limitation on the prices which patients are charged.

Section 223 of H.R. 1 would certainly be a start toward the market place. Why, though, not go the entire way? Why not combine the benefits of open competition with those of cost-based reimbursement? Let us look at how this might be done.

The Secretary would prepare a set of specifications for services to be rendered. At first the number of services covered by specifications would be somewhat limited to those most widely used, and very possibly computed on an all-inclusive basis, such as laboratory services per patient day. With experience, almost all services would be covered by a specification. After receiving these specifications, each hospital would submit a bid stating the cost at which

it would agree to provide a unit of service during the next contract year.

For each specified service, the Secretary would compute the weighted average of the bids submitted for a given geographic area, and establish that average as the reasonable cost of the particular service.

Any hospital which submitted a bid higher than the published average would have the right to charge the patient for the difference. Alternatively, it could choose to absorb the loss that it might incur in the providing of the specific service. If the hospital did choose to charge the patient, its total payment for the service could not exceed its total costs for the service.

The hospital which provided services at a cost less than the published average bid would share substantially in the savings up to the difference between its bid and the published average bid. To encourage low bidding there would be a much reduced sharing in any savings resulting from services' being rendered at a cost below the bid.

For illustration, Hospital X bid \$8 for each unit of a given service. The weighted average was computed at \$10. If the hospital actually rendered the service at \$8 it would receive, say, 50 percent of the savings, or \$1. If its costs were \$9 it would receive 50 cents per unit.

However, if it over-bid, its reward would be proportionately smaller because its percentage of the savings would be reduced dramatically. If hospital X rendered the service at an actual cost of \$6 per unit, it would receive perhaps only \$1.20 as its share of the savings. It would receive 50 percent of the savings between the published average and its bid, but only 10 percent of any further savings. Since the additional savings were \$2, it would receive only 20 cents of that. If, instead, it had bid the \$6, it would receive 50 percent of the savings of \$4, or \$2.

Obviously, the encouraging of low bidding would be advantageous to the Secretary in that it would lower the computed average bid. Low bidding also would promote greater efforts toward goal achievement.

Inherent in any method of reimbursement on a unit basis is the possibility of excessive utilization. To eliminate the incentive for overutilization, the hospital would be paid only its marginal costs for services in excess of some determined standard, e.g., length of stay. On the other hand, some reward mechanism would be developed for those hospitals that effected reduced utilization.

If a hospital bid below the average, and for

some reason its actual costs exceeded the published average, it would be permitted to carry its loss forward and, if it chose, recover the loss through charges to the patient in the future period or periods.

The implementation of such a reimbursement system would almost certainly guarantee a rational and thorough evaluation of proposed capital investments. Some sort of cost benefit analysis would seem to be assured. It is interesting to contemplate whether, under such a free market system, planning agencies would have any work to do. Would not the market itself preclude unneeded facilities and encourage those for which there is a demand? Would a hospital build a new facility with debt funds if its depreciation and interest were going to result in a unit cost \$40 above the average?

I might mention here that one of the questions that would have to be answered here, since the market place is going to govern, is that which Joel asked, "What does society want? What does society think we should provide?" With the free market place concept, indeed it is society that will determine whether it wants to pay the price for what we determine society should have.

The whole working of the free market is governed by how it affects the consumer and his pocketbook. Obviously, then, there would have to be some prohibition against total insurance coverage. I would have to leave it to the insurance industry to determine whether or not the insuring of this excess payment would be a marketable commodity that could be soundly underwritten. It may not be, since 50 percent of the services available would be rendered at no cost to the patient because of the use of a weighted average in the determining of reasonable cost.

If indeed insurance could be available, then very possibly legislation would have to be passed that insurance could not be written for the first so much of this excess charge to the patient. Perhaps insurance could not be written for the first \$500. Then the decision would be forced upon the patient to choose the more efficient operation and pay nothing, or pay for the above-average costs from his own pocket.

The consequences of inefficient operation are quite clear. However, for a rather extensive and excellent presentation of the matter, I would refer you to *An Analysis of Reimbursement Plans*, by Paul J. Feldstein in the aforementioned Research Report No. 26.

There are those who will argue that a reim-

bursement method such as that which I am proposing only treats one part of the health delivery system. Admittedly it does. But the part it treats is the one that has received the greatest attention and appears to be of the greatest concern.

In addition, it is a program which could be implemented with little or no significant change in the traditional relationships which currently exist among the various elements of the total health field. It could be implemented gradually and fulfill the Committee's mandate to the secretary to experiment.

However, for the hospital industry to accept such a proposal, there would have to be assurance that the efficient operations will be able to continue in existence when they are the only ones left. With a free market economy it would be safe to assume that only the efficient operators will be in business in the future.

Since there will be no meaningful cost savings because all the remaining hospitals will be operating at comparable, high levels of efficiency, the published average bid cost must provide for the hospital's total financial needs. At the present time the Federal Government's definition of costs does not meet this criterion. If the market place is to be given its chance, the definition must be changed.

Think about it.

CHAIRMAN MAY: Are there any questions of Harold at this point?

### QUESTION AND ANSWER SESSION

REMARK: On the last example of how the market place incentives might be mixed with cost-based reimbursement of these covered service specifications, it seems to me it would be quite the opposite from specifying incentives in the market place, and it is in fact to collude under a regulated system. That is, in fact it is inviting collusion on raising one's bid to the point where you are pressing the average up, and in fact inviting the hospital industry in any particular region where this might be placed.

MR. HINDERER: Very possible. It is very possible it could invite collusion. But I look at it this way:

Let's say I know when I see the specification that I can render the service at \$5. Let's say the average comes out \$10. If I had bid \$9 to

protect myself, and I rendered the service at \$5, I would have given up the possibility of \$2.50 of mine to change it for 90 cents. I would have gotten 50 cents here, and I would have gotten 10 percent of \$4 here, or 90 cents. I think competition would say that this collusion bit is nothing. If I can run this job efficiently I am not going to trade \$2.50 for 90 cents.

QUESTION: Is this unit of service you are talking about a particular lab test or lab services?

MR. HINDERER: I don't know; it could be either one. It could be worked out either way. I would think, to start with, the Secretary would specify routine laboratory services, identify what they are, perhaps per patient day. Eventually, as time goes on it could be bid on each particular laboratory procedure.

REMARK: It could be awfully confusing, because we offer some 750 different lab tests, some of which aren't offered in other hospitals. If you lump them together, then, the costs are higher than you are going to find in other hospitals.

MR. HINDERER: That is why I think we would have to define routine laboratory services as, let's say, just off the top of my head, urinalysis, complete blood count, hemoglobin, and so on.

QUESTION: What do you do if you find out in one hospital this laboratory is lower and physical therapy is higher? How do you make your decision when you lump them all together? How do you make the decision which hospital you are going to send the patient to when you lump them all together and find one is higher in this area and lower in another?

MR. HINDERER: I would visualize that the hospital will levy a per diem charge to make up for the losses it has. Instead of saying you have to pay 80 cents for a lab test, if its over-all type thing is higher, then very possibly levy \$2 a day to make up for all of its services. It could be done by individual units. It could be published.

REMARK: In your example, it specifically relates to institutional incentives, but it doesn't encompass professional incentives to the point where we have said that the physician is making the health care decisions, and the bid process

taking into consideration the aspects of underutilization or overutilization components.

If the institution is working for underutilization or appropriate utilization at an appropriate bid, how does that reflect with the radiologist who has a professional interpretation for every film he takes? You are going to decrease, hopefully as a standard, perhaps, the utilization.

MR. HINDERER: That's right.

QUESTION: How does that correlate with what the radiologist as a professional feels?

MR. HINDERER: He wants more, do you mean? I think today, just on the pricing sector, I would visualize that in the long run we are going to have the total concept, the HMO concept, on that. There is no question about it. I propose this as an intermediate step, a first step that could be taken today. If the radiologist says more, do you mean order more tests or more procedures in there than what would be considered the standard for here?

REMARK: Based on specific indices of care that may be appropriate; but perhaps it didn't reflect in your bid.

MR. HINDERER: The only thing I would get for above-normal utilization is my marginal cost.

QUESTION: Does this presume standardization of wages?

MR. HINDERER: No. I think in a free market the wages would standardize, yes. I think they would have to. How different are wages now in a given area? You have a pretty free economy, a pretty free market, in setting wages. There are some differences, but certainly there is an incentive for the man to keep wages under control under this scheme.

There is no incentive to go out and boost wages for piracy or liberation or whatever you want to call it. If I in my hospital say, "Boy, I'm going to liberate these nurses from the hospital down the street," I know my costs are going up. If my costs go up, it cuts down on this sharing that I am going to have.

QUESTION: I didn't really catch your answer to the question. What do you do about changes in, if you will, severity of illness of patients other

than as specified? It seems to me it is quite possible to specify. Some hospitals have sicker patients compared to a community hospital.

MR. HINDERER: Severity will have to be written into the specifications. It could be. That is entirely possible.

CHAIRMAN MAY: That he can't win by bidding on those people, though, if he is the only bidder.

MR. HINDERER: He will get his full costs.

CHAIRMAN MAY: It strikes me that one of the things you are sort of implicitly saying, and sort of abstracting from the detail of what you are proposing, is that reimbursement formulas can be used more as a carrot than as a stick. And so far we have seen them used only as a stick. Could you elaborate a little more on that?

MR. HINDERER: Admittedly this is just a concept, no question about it. A lot of detailed thought would have to be given to it. But we see proposed in H.R. 1 the idea that the Secretary would set this average—that he is the one who would set it.

What I am proposing is that instead of this, the market place set it. I would know beforehand, and I would have to think and I would have to say beforehand, this is what I can do the job for. And if it happens that other people can do the job cheaper, then I have to look and see what I can do to get this down.

The other advantage of this is that I would know what the target rate is before I start this year's operations. We would all bid. I would know what the target rate is. Under most of the proposals we have seen, the reimbursement is that here you get this, and that is all you get, and that is the ceiling. It is to stop costs going higher. With this approach, the reimbursement mechanism is that there is a true financial incentive for you to do the job better.

QUESTION: When you say "average" are you talking about national average or regional average?

MR. HINDERER: No; the average for a geographic area.

QUESTION: Assuming that Harold is right (and I suspect he is), that some type of competitive

approach is going to be used, I can't help but feel that that is leading us very definitely in the direction of the profit-making business. Maybe that is not so wrong. Most of us have lived in another world.

My feeling is, Harold, that all the things you have outlined there are the kind of things that are incentives to people who are in business to make money, and that may very well open up Pandora's box. My feeling is in fact that profit-making people are standing around the side right now, looking at this total picture and trying to figure out what the next moves are for them to make. Do you have any comment on that?

MR. HINDERER: Yes, Leon. When we say profit-sharing, I think with the financial needs that the voluntary system has—and I mentioned the present reimbursement formulas do not meet these needs adequately—rather than this being a profit that I am looking for, this is the opportunity for me to meet my financial needs. It has this control mechanism in the free market place, that there is no question that people will go out of business.

One of the things (if this were done) is that there is no question in the world that the Federal Housing Administration would own some hospitals. With the ridiculous loan guarantee that is going on here, these people couldn't stand it in the market place, and the FHA would have to take over, and there would have to be reorganizations, no question about it. But the market place would drive the inefficient operator out. If it were in an area where the people had no choice, the people can voluntarily choose to pay for it.

QUESTION: Harold, you indicated that the University of Chicago hospitals would obviously be in a class by themselves in terms of bidding on the degree of care. That means to me that you would establish some sort of classification system. How would you work that?

MR. HINDERER: Arnie, let's take surgery for example. Surgery could be classified in various strata. This is not unknown today. You and I know of many cases where a hospital can take its total surgery and classify it in eight, ten, twelve different categories depending on inten-

sity and need. The hospital would bid on a type 1 surgery, a type 2, a type 8, a type 5 surgery. Related to those would be days of care established, the normal average days of care related to that type of surgery. This is what it would bid on. If it is a type 2 surgery we would bid this much for the surgery, and this much for each day of pre- and post-surgical care.

QUESTION: It seems that for the for-profit hospital it is obvious that the needed gains from having costs lower than average can accrue to the stockholders. Therefore there is no problem in the long run in liquidating these excess profits or excess payments.

What would you see at the long-run incentive to the not-for-profit hospital for doing anything besides being even? I can't see that they can gain anything, since they are not allowed to raise their costs without changing their relationship.

MR. HINDERER: In the early days, in the first decades or years, whatever it might be, he could accumulate capital to make up for the deficiencies that exist. Eventually he would get to the point where only the efficient operators will exist. There will always be the incentive to operate well and to stay on their toes, because the minute a guy does not stay on his toes his costs are going to go up and somebody else is going to reap a little bit from his inefficiency, and he is going to be put in the position of going to the market place and saying, "I have to charge you this because I got a little bit lax. I got fat."

So, the incentive is continually there.

There is the disincentive or the incentive to perform well because of the penalty that would be involved, the exposure to the market place of your inefficiency, and there is always the other part—that I will keep operating as efficiently as I can because maybe the guy down the street will get a little fat and lazy and I will get something because of it.

I did say as a condition that when we do get to that level we must be sure that that average (if they are all the same) will always provide for his total financial needs, so that he can continue to operate as a free and voluntary member.

QUESTION: If your example could either include the analysis of reimbursement of a single test or if, as you said, it could include all of the lab tests, could you expand that to include a cost per patient day?

MR. HINDERER: Absolutely.

REMARK: I don't see any sense in buying an \$8,000 Mercedes and having somebody tell me the carburetor only costs \$8.

MR. HINDERER: No question about it. If we take this to the ultimate conclusion we would go to what Paul Feldstein brought out so clearly and so well—that the incentive has to be attached to the final product, ultimately total health care.

QUESTION: What is the final product?

MR. HINDERER: The final product is total health care, the capitation type of thing, where we have the responsibility for total health care.

QUESTION: In the interim, or are we selling patient days? Are we selling cost per day? What are we selling?

MR. HINDERER: In the initial stage we are selling exactly what we are selling now.

QUESTION: What?

MR. HINDERER: Acute inpatient care and outpatient care.

QUESTION: And at what rate—cost per day, cost per stay, cost per stay by individual diagnosis, cost per day by arbitrary individual departmental costs?

MR. HINDERER: We could be selling it on almost any basis that we can think of. I would think of this as a cost per day by diagnosis with, as I mentioned before, a tradeoff after some kind of predetermined average. So, if eight days were the average for this, I would bid on so much per day. If the stay went to 15 days, I would not be paid for the 15 days on my bid price; I would be paid for eight days on my bid price, and I would be paid only my marginal cost for the next seven days. If instead the average went down to seven days, if my average was seven instead of eight, I would be given a reward for effecting a reduction from the standard.

QUESTION: What would you do with a hospital that is in a changing neighborhood and is moving



into a high cost situation because of it, to stay, and on the other side of the coin what would you do for a hospital that ought to start in a neighborhood that needs the facilities and, because of high cost of construction today, would have to start with a high cost situation?

MR. HINDERER: The hospital that was going to go into a new neighborhood—if there was a need for it, the market place would dictate. There would be an evaluation. Is it economically feasible to build this hospital there? Can this neighborhood support it, and will it support it? I am assuming one thing throughout all of this, and that is that there is no more free care—that total care for the total population is financed one way or another.

REMARK: Except, take the situation of a hospital that is in a changing neighborhood.

MR. HINDERER: All right. What do you mean by a changing neighborhood?

QUESTION: A high mobile neighborhood, or a national or racial changing neighborhood, where you have a great fluctuation of occupancy, where you have a rising cost situation. On sheer competition, on a business approach, you ought to close the hospital. In terms of community need, that hospital should stay. How would you adjust your proposition to provide continuing care to such a community?

MR. HINDERER: First of all, are these people capable of paying for the care themselves?

REMARK: Usually not.

MR. HINDERER: If they are not, then it would fall upon the state to do this. If this hospital had to pay more, had to charge more than the published average—and I think you get down to a very serious question of why it would have to charge more—we make an assumption that if it is in a changing neighborhood its costs are going to go up. I don't think I can buy that assumption. Why would its costs go up?

REMARK: I would have to say because experience has shown it. I don't want to get into it in depth.

My point would be this: It would seem to me that there are certain conditions other than

economic that would need to be evaluated, and that you would have to make certain adjustments, and the moment you do that there is a problem now as to who will evaluate and who gets these special considerations and who doesn't. I am saying it is not as simple to provide a basic proposition where some special consideration must still be given.

MR. HINDERER: All right. Let me put it this way to you: What determines the price of bread in a grocery store? The free market, pretty much. Some of the people, though, don't pay for that price of bread, do they. Some of the people pay considerably less for that price of bread, because somebody has determined that it is for the social good that government should help pay for that price of bread.

QUESTION: In the proposal you just made, I see some problems in the areas of teaching. Let's say you are in an institution that didn't have any extra teaching funds, such as a medical center, yet you have residents and interns in that institution. I think you would provide a non-incentive to do some extra lab tests and any kind of extra ancillary services. Will you respond to that?

MR. HINDERER: You say extra lab tests. I say this is where it is so essential that we distinguish between the fixed and the variable costs. Doing some extra lab tests, we have to look at what are the variable costs, the marginal costs, associated with the extra lab tests. It may well be that we could do, instead of X, we could do 1.3 X for pretty much the same amount of money—not very different at all.

The volume in the teaching school should give me an economy of scale that would reduce my fixed cost per unit. The teaching hospital almost without exception is a large institution and has a much broader base over which to spread its fixed costs.

One other thing with the teaching hospitals that I think we would have to think about is this: Remember, my assumption is that there is no free care, which is one of the bid loads that a teaching hospital has to bear today. Isn't it possible that the teaching hospital would give some real thought to cooperative programs with some of the other hospitals in the area?

You know, it has been my experience in battling around for twenty-odd years in the hospital field that we have the teaching concentrated not because the other hospitals don't want to participate in the teaching program, but because the central hospital does not let these other people in and let them participate. Maybe this would help spread the advantages that accrue from medical education throughout the whole community as well as spreading some of the costs.

REMARK: I come back to the very crucial point of average that you are basing almost everything on, and you are using a loaf of bread or an industry. A patient's health is not average, because no five people have an average length of stay. How you came in, what your age is, what you are going to do. There is no one who can legislate that. Then you say the state will have to come in. If the people who are doing their best now can't do it, the state cannot do what the individual with the same motivations that anybody has to try. So, using the average as loosely as it would be used in application to marginal costs and incentives, I don't know how you can use it, whether you are saying geographically or an institution. You still can't say average patient cost.

MR. HINDERER: Remember that an average

can be valid if the universe upon which it is computed is broad enough. With the experience we have, with your own experience, knowing the types of patients you have had, you can take it by category and come out with averages. Sure, some maybe will go above, some will go below; but the hospital that bids on an average, where the average is determinable, if it goes beyond the average the hospital is not penalized. We mentioned the hospital will be paid its marginal costs. The only thin is, the hospital will not be rewarded for encouraging excess utilization.

QUESTION: Do you think your concept is somewhat limited to your urban areas where there are competitive units not too far apart, with great volume, and hence the typical market concept?

MR. HINDERER: I really don't know. We have taken a look at the state of Oklahoma. We just took a look at this. From a limited sample—and this is not a valid statistical sample, I will grant you that—it may seem that you could take rural areas in general for the whole state of Oklahoma. It may be entirely possible.

CHAIRMAN MAY: Thank you very much, Harold. You certainly were provocative.

## Prospective Budgeting in Three States

JACK W. OWEN, DENNIS P. MAY, and LAWRENCE A. HILL

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CHAIRMAN MAY: It also occurs to me that all of the questions that were asked, and all those that were pending, and all those which formed in your minds but which you didn't ask, are exactly the kind of questions we want to be dealing with during this day and a half, in terms of what is the implication of various control mechanisms for hospital operation. It is very, very pertinent.

The next three people who are on the program are listed in inverse alphabetical order. I was trying to think of how I should list them, and decided that was the best way. They represent three different states, three different approaches to a very important ubiquitous kind of activity called prospective budgeting, and each has been involved for an extended time with, for, in or against the development of this in their particular area. One at a time, they will talk to you about their own experiences, and I believe we will be able to relate them to what we are talking about pretty well.

Jack Owen is President of the New Jersey Hospital Association. He is an alumnus of our program in hospital administration, and a great friend.

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MR. JACK W. OWEN: Thank you, Joel. I certainly appreciate having this opportunity to come here; and especially since I have two of my Board members sitting in the audience, John Peterson and John Imhoff, I had better be careful what I say. I asked John Peterson last night how he could sleep with all these controls and things we have been hearing about. He said he sleeps like a baby. He sleeps for an hour and then he wakes up and cries. [Laughter] I can't say that I blame him any, because there are days when I feel like crying, too.

What I thought I would do for my period of time is to give you a quick summary of how we got into our budget review program, what our objectives are, what has happened since the passage of our new control law, where we stand

at present, how hospitals are faring, and what are some of the problems we can foresee. If I can follow in that order I will be doing great.

First of all, let me say that in New Jersey we were faced with a problem back in the early 1960s. Our hospitals were on a cost reimbursement system with Blue Cross, and our problem was that the Commissioner of Insurance had established a ceiling—an arbitrary ceiling—which was designed to catch the fifteen higher cost hospitals in the State; so that as costs came in at the end of the year and were audited he would arbitrarily draw a line beneath the top fifteen and say that was the ceiling, and anyone above it had to have a review. The review was done by a committee of Administrators appointed by the Commissioner and staffed by the New Jersey Hospital Association. The hospitals involved were usually the same ones year after year.

The problem they encountered was they did not know in advance how much to budget for the year for expenses, because they didn't know whether they were going to be allowed their expenses at the end of the year. The other problem was that they did not get this money until almost two years after the time they had expended it, and this created a serious cash problem.

The ceiling in 1967 was \$60 a day. In 1968 it was \$68.50, and then the Commissioner of Insurance decided to freeze it there so that all the hospitals in the state were gradually forced into this review process.

In 1968 we had a meeting with the administrators of some seventeen hospitals in the state, and suggested that perhaps if they were willing we would go to the Commissioner of Insurance and seek some relief from this retroactive payment process, and if the hospitals would submit their budget for review then the Commissioner could set that rate as the prospective rate.

The hospitals agreed; but again, being good Association men, knowing that there was a lot riding on this, we suggested that they get the presidents of their boards of trustees also to come in and agree. The presidents of the boards

came together, and there was quite a lot of discussion as to whether a community hospital should be accountable in the fashion we were talking about—in other words, accountable to the state. Fortunately the men who were the heads of these hospitals believed this was the case, and that they should have someone other than their own community board review the budget.

We then went to the Commissioner of Insurance and asked him to establish a budget review program. He agreed with the seventeen hospitals, and they we found we ran into a problem with our Blue Cross Plan, because what this did to Blue Cross was to immediately create a larger payout, as they would pay prospectively rather than two years afterwards. So we had to go through another round and bring in a lot of political pressure in order to force the issue. You might ask: Why would you want to force an issue for this kind of control? I think it was basically that the hospitals really believed somewhere along the line something was going to happen that would create problems which the retrospective reimbursement would not solve, and certainly the accountability was there.

This was back in 1968. We got agreement and we started out with a program. We were fortunate in organizing the program in our Hospital and Educational Trust separate from the Hospital Association. The Commissioner appointed an advisory committee which was made up of three physicians, three hospital trustees, and six hospital administrators. This was going to be our effort at peer review. They were strictly advisory, and the Commissioner of Insurance had the final say on any rate that was established.

The hospitals, in order to finance the program, pay \$2,000 to have their budget reviewed in order to get it cut by some \$300,000, so you can see we have some very forward-looking administrators. This is the way the project is financed.

What we were trying to do was, first of all, to determine whether prospective budgeting was feasible with all of the problems that come with volume and some of the other factors I will touch on later. Secondly, were the hospitals ready for this kind of review? Were they ready to prepare budgets and live with the results.

We went to Stan Martin and talked with him about what was being done in Ontario, because at that time they had the most experience in budgeting. Eventually we wound up with a bud-

get form that is 30 pages long. If anyone would like to look at it, and if you want to know how to fill it out, I suggest you talk to John Peterson or John Imhoff. It is a very, very inclusive document, and covers just about everything in the hospital. We are talking about not only the operating expense areas, the housekeeping-hotel services, but also the professional areas as well.

The hospitals submit the budgets to our review group, and our staff in the Trust then reviews them, does the statistical work on the budget, and goes back to the hospitals for any additional information.

We were trying to accomplish three things in this program. First, we wanted to eventually get on some kind of a true prospective rate. I will tell you right at this point, at this time we are not really on a prospective rate. We are on a prospective tentative rate; so the hospital is paid on that, but at the end of the year there is still a cost audit, and if the hospital goes under the tentative rate that money of course is just returned to Blue Cross. If they go over, they have an opportunity to come in for a hearing on a cost review. We were hoping that first we would get to a true prospective rate, but we had to find out what the effects were going to be. We had to find out how to handle changes in patient days, which, of course fluctuate; the problem was pointed out in some of the questions raised by Harold; and were we going to be paid on a patient day basis, a case basis, and so on.

Secondly, we wanted to eliminate discrimination in rates. By this I mean we are in a situation where in New Jersey most of our reimbursement is on a cost basis, and we have very few private pay patients left, and we are getting a wide spread between costs and charges. It is running somewhere between 25 and 30 percent at the present time.

You will be pleased to know that on Wednesday twenty-two of our hospitals received notice of a complaint or suit against them by Local 464 of the Meat Cutters Union Welfare Fund, charging them with discrimination in pricing. This is going to be an interesting one, because in effect what they are saying is that it is the hospitals that are to blame for contracting with Blue Cross for a lower rate, rather than blaming the Blue Cross Plan as Travelers did in Pittsburgh. We don't know how that is going to come out, but our goal back in 1968 was eventually to get to eliminate discrimination. If some-

one went into the hospital, no matter how he was covered for a particular service, he would be charged the same rate, and the hospital would be reimbursed that same rate.

Thirdly and most importantly, we wanted this to be a fair, equitable program for the individual hospital. Here we wanted to avoid the grouping that we were seeing so much of around the country. In other words, grouping together three or four hospitals by size or by service, because in our opinion this was only going to lead to mediocrity—that once you start with a group and you get an average, there are some high and some low, and the rate is at the average; the high suffers and the next year he is going to drop down, and the first thing you do is bring the average down lower and lower.

We wanted to develop a plan where each hospital would be looked upon in its individual setting, and where a profile would be defined for each hospital, and the rate would be related to its operation rather than to the operation of other hospitals. This is still our intent, but in order to get the program started we had to use some averages from the standpoint of looking to see whether a hospital had some problem area. Perhaps I can show you what I mean by that in a couple of minutes.

Basically we were trying to end up with a rate for a particular hospital which would be like a public utility rate which is related to the individual utility's ability to deliver a service. For instance, we have a number of water companies and electric companies in New Jersey; each one charges its own rate based on the service it has to provide, and based on its expenses. We were hoping that this is the way we would end up with our program.

This was a strictly voluntary program. It was started out primarily by the Hospital Association for the high-cost hospitals, and it was developed and paid for by the institutions that were going to be controlled.

Last year things changed a little bit in New Jersey. We had a hospital control bill passed, and this bill is a very stringent one. It affects certificate of need, licensing, reimbursement, and the whole works. In fact, the only groups left out are the solo practitioners in their offices. Even the group practice of medicine is included, HMOs, the whole bit. The solo practitioner is included once he admits a patient to the hospital. He is then considered part of the system and under the same controls. All of this is by the Department of Health. I am only going to talk

about the reimbursement part of it, because that is what we are here to discuss.

Let me just read to you what our law says in regard to reimbursement:

A—No government agency and no hospital service corporation under the laws of the State shall purchase, pay for, or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided the health care facility possessed a valid license or was otherwise authorized to provide such service.

B—Payment by government agencies for health care services provided by a health care facility shall be at rates established by the Commissioner based on elements of cost approved by him. (That takes care of all government payments except Medicare. That is municipal, county, and Medicaid.)

C—The Commissioner of Health, in consultation with the Commissioner of Insurance, shall determine and certify the costs of providing health care services as reported by health care facilities which are derived in accordance with the uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of cost taken into consideration.

D—Payment by hospital service corporations organized under the laws of this State for health care services provided by a health care facility shall be approved by rates as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health.

We were able to put one sentence in here "In establishing such rates, the Commissioner shall take into consideration the total cost of the health care facility." That was the best we could do in changing this. There was a tremendous political impetus to put this kind of control on, and I am sure many of you will find it happening in your states as well.

That brings us up to where we stand now with our budget review system. The first thing that the Department of Health wanted to do was to throw out the budget review system as it exists in New Jersey, and to go to the New York system, which is a grouping of hospitals. A rate is established which is a true prospective rate, and everyone gets it. If you are above it, too bad; if you are below it, you make out.

We had watched very closely what was happening in New York City, and we felt the hospitals there were not in good financial shape, and we didn't want that to happen in New Jersey. After much political maneuvering we were able to get the Department of Health to agree to stay with the budget review program through 1973. At that point in time a decision will have to be made as to whether we continue to operate the program as we now have it, or whether we

go into some other program which the State will establish.

Let me tell you a little about what this program is, and what we are trying to do. First of all, we found out as we looked at the budgets that there we could identify differences in hospitals. I don't have to tell you what they are. Some hospitals have educational costs, some hospitals are in a new building in which they have large depreciation costs, and other hospitals have none of these. So, I might say that although our program is not perfect, and we know there are a lot of errors in it, and we know a lot of the data from the hospitals is not completely accurate, we think we are getting a good picture of what is happening.

We decided we would separate the educational costs and all depreciation costs, because these costs had to be paid. (However, a special committee was subsequently established to see how much education a community hospital should be giving. Was it overextending itself?)

We then came up with what we call a modified per diem rate. The modified per diem is the controllable cost to that cost which we feel most hospitals in the State encounter for the same kinds of services. There are some differences, as you can imagine; but within that they all have lab services, they all have x-ray, they all do surgery, pediatrics, and so on.

This was about the best way that we could come up with for comparing these hospitals as we looked across the State, because the hospitals would say, "How come our budget is being cut, when down the street that hospital didn't have it cut?" Then we would start comparing the two hospitals and would find out that the HAS statistics and other things they were reporting were not accurate, and that there was always something different. Somebody said the only thing uniform so far that has come out in any of these programs is that it is black ink on white paper. That is pretty much what we found.

Let me tell you what happened in 1971, for instance, to give you an idea—

REMARK: And even that is changing.

MR. OWEN: Yes; now it is blue ink on white paper.

I want to show you these figures because I think this gives an indication of one of the things we were trying to do in this program, to see how well hospitals can budget.

I might go back for a second. The hospital

did not have to come in for a budget request if it was satisfied with its last-year Blue Cross rate. That's not funny. I want you to know there were almost forty hospitals that did not come in last year. You can smile, but it happened. So, we had about sixty hospitals that came in. They wanted in their budget \$470,478,000. That was what they requested in their budgets for 1971. They were approved for \$461,577,000. Actually there was a reduction of some \$9 million in these sixty hospitals from what they requested and what they were approved for. They actually came in at \$465,102,000, or they were over budget \$3,525,000, or .76 percent, or  $\frac{3}{4}$  percent off budget. I think that is a real credit to the hospitals in New Jersey, to be able to come in that close on \$461 million of expenses, and to hit it within \$3 million.

The problem is that the patient days fluctuated considerably last year. I think this was true all over the country. It brings up one of the points I referred to earlier, and that is patient days is a poor way of reimbursing. I think our unit is wrong. What happens is that so many patient days were predicted for a certain amount of money, and we missed the days by some 9.5 percent in New Jersey. 9.5 percent was not enough so that the hospitals could reduce budgets by that amount, because their expenses are essentially fixed expenses and there is no way with that small decrease in patient days that they could take up the slack. So, it appears that we have to look at this in a different fashion if we are going to look at prospective rates somewhere down the line.

One thing I would point out is that Blue Cross knew in New Jersey in April of last year that it was committed to approximately 50 percent of this \$461 million, because that was the total of the notes approved by the Commissioner of Insurance. We now have a Blue Cross rate increase with the public defender and all the rest on Monday. They say hospitals are not able to hold down patient costs even though the review system is in effect, which is not true. It was only that the patient days fluctuated.

In 1972 to date we have 100 percent of our hospitals in, not because all the hospitals wanted to come in but because of our new law requiring every hospital to come in. To date we have \$779 million plus that has been requested, and the advisory committee to the Commissioner has approved \$747 million, or a reduction of \$32 million in the hospital budgets to date. That is a pretty good chunk.

You can understand the reason why the committee has taken this action. It has a good bit to do with the wage price freeze and with whether the hospitals can receive the funds even if they are approved over the 6 percent. We still don't know what our base price is, so we are still hooked on that one.

I might say this is not a peer review group that is just backslapping and saying, "Okay, you have a budget. Next week maybe mine will be in, and you will do something for me." It doesn't work quite that way. These people are appointed by the Commissioner. They report to the Commissioner. At the present time we have five sub-committees because of the increase in the number of hospitals. We have five physicians; five trustees and ten hospital administrators who sit on these advisory committees with a public member as the chairman. My own personal feeling is that we ought to have some labor people on there, because I really think the hospitals would fare better with a couple of labor people sitting on the Commission. The hospital people are very tough on one another, and I think sometimes unduly so.

As you can see, this is pretty much where we stand. What does it mean, and how is an individual hospital affected? Let me give you an example of the kind of thing the Budget Committee looks at. This is an actual example:

We are talking about hospitals over 400 beds. I might say in New Jersey we have 100 voluntary hospitals with an average bed size of 328 beds, so they are all fairly good sized hospitals.

In 1969 the modified per diem, after you take out education, depreciation, and so on, was \$61.57. In 1970 it was \$69.60, and in 1971 it was \$78.49. These are actual audited costs at this stage in the game.

We had a hospital that came before our Budget Review Committee. This is how that hospital operated: It was over 400 beds. Its modified per diem in 1969 was \$65.74. In 1970 it was \$73.50, and in 1971 it was \$91.00. Their request for 1972 is \$107.35.

The kind of question that the Committee is faced with is, "What happened to this hospital whose costs were in line with the rest of the hospitals in 1969, and just a little out of line in 1970, but for 1972 was projecting a 24 percent increase, whereas other 400-bed hospitals were anticipating only a 14 percent increase?" This is where the Review Committee goes into depth as to why this happened.

This is exclusive of educational costs and exclusive of depreciation. The point here is that because of this size hospital, they have a lot of educational programs; and you can imagine this can be a big argument about what their educational programs are.

We break the budget down by department costs, administrative and general, operating rooms, supply, linen, and so forth, with each cost center. What we try to do is to get the hospital to explain why it went up this much. Not what happened to the other hospitals, but what happened to you. That is your profile, right there. What happened to you in these four years?

I think it works pretty well. As I said, we have some problems with it. We have a problem with volume. How do you predict what is going to happen next year on number of days? We have been going up approximately 10 percent in patient days in New Jersey for the last ten years—just automatically 10 percent. Last year we went up about 2 percent. What happens? Who can predict that? Yet if you are on a patient day kind of basis of payment you see a great increase in the cost per single day.

The length of stay also has a lot to do with it. We review length of stay by Blue Cross diagnosis and by over-all. One of the things we ran into was that a hospital would say, "We get all the sick patients," like the University of Chicago gets all the sick patients. We started to pull these out to see if they do get all the sick patients. We found the hospital that thought they were getting all the sick patients, was not so, the hospital down the street was getting just as many sick patients, yet they were getting them out a day or two ahead of the other, with the same diagnosis.

The Committee also takes into consideration that when your length of stay is long you reduce your costs. If the stay is short, you get a plus factor added to the budget, which allows you to have a few more dollars a day.

If we are really going to have good prospective rating, in my opinion we have to get off this patient-day basis of payment. I don't know if I have the answer. Certainly the per-case is one way to look at it, but there is another way. For a while I had the dubious honor of running a bankrupt hospital in New Jersey, and I worked out a system which was almost accepted by the Commissioner and our Blue Cross Plan. I

thought it might have some merit. We might get some more hospitals to look at it.

What we did was to work out a very simple formula, Blue Cross had 40 percent of the patient days in this particular hospital. Sometimes it was 41, sometimes 42, but over the last three years it had 40 percent of the patient days in the institution—and I am talking now about inpatient only. This \$3 million is inpatient cost, by the way. This is the budget for inpatient expenses.

We said, if that's the case, why doesn't Blue Cross just pay us \$1,200,000? That is their obligation, and we take care of their patients, and we don't worry about whether the length of stay is short or long, or whether we have to have all these accountants around that Harold keeps putting in business. Then at the end of the year we would look and see how many patient days we had taken care of.

Did the 40 percent change? If so, we would reconcile that. Also, if we came in below the \$3 million, we would be allowed to keep 50 percent of the difference. If we went over it, we were going to suffer 50 percent. We didn't know how this was going to work out, either.

Both the Commissioner of Insurance and the Blue Cross Plan initially agreed to do it, so this hospital was to get \$100,000 a month. That would be the way the hospital would be reimbursed as far as Blue Cross was concerned. This would avoid a lot of audits and other things.

There are a lot of problems with it, and it is not the only answer, but it is a very simple way of approaching the problem. We know 83 to 85 percent of the costs are fixed in almost every hospital. Once it is decided what the services are going to be, you can vary your food, your medicine, your linens a little bit with fluctuation, but you can't lay off a lot of people every time the census goes up or down, because tomorrow you don't know what is going to happen. It seems to me this might be something that could be piloted and that would be worth a try.

Further, I don't know what is going to happen as far as our prospective rating in New Jersey is concerned. I hope we can stick with our original goals and that we convince the Department of Health that the three things we want are a true prospective rate, and to the discrimination between charges and cost, and that we can get away from this lumping of hospitals together. That is going to be the toughest one we will have to overcome, because it is not being done in too many other states.

That, very briefly, is our program, Joel.

In his presentation, Mr. Owen referred to the Health Care Facilities Planning Act, New Jersey Senate Bill 2088. It is included in the following appendix:

HEALTH CARE FACILITIES PLANNING ACT  
NEW JERSEY SENATE BILL 2088  
1971

The Act opens with a firm statement of the State's Public Policy to provide for the protection and promotion of the health of the inhabitants of New Jersey.

PUBLIC POLICY

"Hospital and Related Health Care Facilities

1. of the highest quality
2. of demonstrated need
3. efficiently provided
4. properly utilized and,
5. at reasonable costs

are of vital concern to the public health."

*Comment:* Although this is not as powerful a statement of public policy as is contained in certain federal legislation such as Public Law 749 which speaks of the "right" to health care of every citizen, the famous constraining clause of Public Law 749 stating that these rights can only be granted under the present pattern of medical practice does not appear in the New Jersey policy statement. It must be pointed out however, under the section on definitions, the private practice of medicine is specifically exempt from the provisions of this act. The intent of this statement of public policy is essentially an operative one in that it defines the arena, i.e., State Department of Health, within which the act will be administered. Secondly the five descriptors of hospital and related health care facilities set up the specific responsibilities of that Department. Each one of these five descriptors are elaborated later in the bill.

RESPONSIBILITY

State Department of Health Central and comprehensive responsibility for development and administration of the State's policy with respect to

1. health planning
2. hospital and related health services
3. facilities providing those services

DEFINITIONS

A. *Health Care Facility*

Facility or institution public—private—health maintenance organization for diagnosis or treatment of human disease including:

1. General Hospitals
2. Special Hospitals
3. Mental Hospitals
4. Public Health Center
5. Diagnostic Center
6. Treatment Center
7. Rehabilitation Center
8. E.C.F. and Nursing Home
9. Intermediate Care Facility
10. T.B. Hospital
11. Chronic Disease Hospital
12. Maternity Hospital
13. Outpatient Clinic
14. Dispensary



15. Home Health Care Agency
16. Boarding or Sheltered Home
17. Bioanalytical Laboratory
18. Central Service Facility
19. Health Maintenance Organization

Excludes institutions that provide healing solely by prayer.

*Comment:* It is not clear as to how Health Maintenance Organizations fit into this picture since in this copy of the bill that phrase was a substitution for the word "prevention" a noun which denotes a function not a type of health care organization. It is probably true however, that this most comprehensive list of institutions included under the purview of the act will include all group practice clinics and organizations including Health Maintenance Organizations, as now defined.

**B. Health Care Services**

Preadmission, outpatient, inpatient and post discharge care provided in or by a Health Care Facility.

Other services carried out under supervision of a physician including:

1. nursing service
2. home care nursing and other paramedical services
3. ambulance services
4. services provided by intern or resident
5. services provided by a physician whose compensation is provided through *agreement* with a Health Care Facility
6. medical social service
7. drugs, biologicals, etc.

Excludes services provided by a physician in his private practice and by practitioners of healing solely by prayer.

*Comment:* It is in the section of the act where health care services are defined where real problems of definition and clarification are likely to exist. Although the list is most comprehensive, matching services with the kinds of facilities in the preceding definition, inclusion of the phrase "services by a physician whose compensation is provided through *agreement* with a health care facility" opens up the entire question of whether an *agreement* means only these physicians who are operating under some kind of salary arrangement that is paid by the hospital or includes those who operate under a percentage contract for the provision of services such as radiology, pathology, etc. If so, this is the first time the professional components of these services have been included in such legislation. Another real question is whether a simple hospital staff appointment is an *agreement* and sharing of professional fees from Titles 18 or 19 which are collected by the hospital for the physician are also covered by the act. This is a critical question in light of the exclusion of services provided. One does not know if private practice is considered as a geographical or a patient relationship concept, because physicians carry out much of their private practice in health care facilities.

**C. Construction**

Erection, substantial alteration, etc. of a Health Care Facility

Equipment

Studies, survey, etc.

*Comment:* An unusual feature of this definition is inclusion of planning, surveys, design specifications, etc. in

to the act. In most such legislation the hospital is permitted to explore the feasibility of a project before submitting this project for approval.

**D. Government Agency**

Department board, bureau, etc. or any other unit of the State or political subdivision thereof.

*Comment:* This means that local government must pay for services at rates set by the State government.

**E. Hospital Service Corporation**

Any corporation organized without capital stock and not for profit for the purpose of establishing, maintaining and operating a nonprofit hospital service plan.

**F. Hospital Service Plan**

A plan whereby health care services are provided by a hospital service corporation or by a health care facility with which the corporation has a contract for such health care services to persons who become subscribers under contracts with the corporation.

*Comment:* Though this definition obviously refers to a Blue Cross Type Plan it may apply to Health Maintenance Organization or Group Practice Unit established on a nonprofit basis.

**RECOMMENDING AGENCIES**

1. State Health Planning Council 749a
2. Comprehensive Areawide Health Planning Agency 749b
3. Area Planning Councils approved by Commissioner

*Comment:* No mention made of Regional Medical Program as having a role in the act.

**COORDINATING AGENCY**

State Health Planning Council 749a

**APPROVAL AGENCY**

Health Care Administration Board

Thirteen members

eleven appointed by Governor (four years) represent medical and health care facilities, labor, industry and the public

two Exofficio

State Commissioner of Health

Commissioner of Insurance

**POWERS OF COMMISSIONER**

Inquire into Health Care Services and the operation of Health Care Facilities Inspection of adequacy of

1. premises
2. equipment
3. personnel
4. rules and bylaws
5. financial resources
6. future revenues

Adopt and amend rules (with approval of the board) re:

1. requirements for a uniform state system of reports and audit relating to:
  - a) the quality of health care provided
  - b) utilization of health care facilities
  - c) costs of health care facilities
2. certification of schedules of rates, payments, grants and other charges
3. standards for licensing
4. provide consultation to health care facilities on operations, planning and standards

Request and be furnished such reports and information required to carry out purposes of act.

Institute a court of competent jurisdiction to compel compliance.

Designate an appropriate organizational unit in State Department of Health to carry out provisions.

Cause appropriate surveys and studies to be made concerning need for health care facilities.

Issue certificates of need valid for one year, renewable.

Establish minimum needs for health care facilities.

#### CONTRACTS WITH OUTSIDE AGENCIES

Can enter with any government agency, institution of higher learning, voluntary, nonprofit agency, etc.

#### LICENSURE

Certificate of need required; no health care facility shall be operated without a license which can be suspended.

No governmental agency or hospital service corporation shall purchase, pay for any health care service provided in a health care facility without a license.

#### RATE SETTING

By Commissioner of Health for payment by *government agencies* based on *elements of cost* approved by him.

By Commissioner of Insurance with approval of Commissioner of Health taking into consideration the *total cost* of the health care facility.

Rate set cannot exceed regular charges.

By Commissioner of Insurance for Hospital Service Corporations to out of state hospitals.

#### CONCLUSION

In conclusion this is one of the most stringent public utility type laws reviewed. The Commissioner of Health is indeed a medical care facilities czar in New Jersey who through certificates of need, licensure and rate setting for governmental agencies and nonprofit third party payers really controls the hospitals in the State. In addition there are few hospital operating areas from quality of care to utilization review to constitution and bylaws that are not subject to review and approval by the Commissioner.

The range of health care services covered in the Act extend far beyond hospital care to include pre-admission and post discharge care, ambulance services outside laboratory services and medical special services. How one can really oversee the quality and utilization of these services without controlling the private practice of medicine is indeed rather questionable.

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CHAIRMAN MAY: I am sure this afternoon we will go into more detail on some of these things.

In order to forestall charges of nepotism, I should point out that the next speaker and I share no genetic relationship except our lack of height. Dennis May, Director of Finance, Connecticut Hospital Association.

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MR. DENNIS MAY: Cousin Joel, Ladies and Gentlemen:

As is so often the case when a number of people are speaking on issues that somewhat overlap, one must be pretty sure of exactly what his niche is in the total program, and what his specific part to play should be. I have a little story along those lines, and it is an old one that maybe some of you have heard. It concerns an aspiring actor who had a single line in his first play, which was, "Hark! I hear the cannon roar!"

This was his first big opportunity, and he practiced the line for weeks and weeks. He would try it in different ways. The night of his opening performance he took a taxi to the theater. Backstage he went over his line with some of the people who were operating the curtains. They patted him on the back and said, "You'll do fine. Just go on stage, and we're sure you'll be successful."

He ran on stage on cue. He could hear the cannon boom, and he said, "What the hell was that?"

I would like to say also a slight disclaimer, just like Jack did, that the Connecticut system we started a few years ago is not truly a prospective system. It is a test of incentives, both positive and negative, and there is final settlement at year end in the Connecticut system. But there are rewards and penalties involved, and it is basically on the reward-penalty idea that I will be speaking.

#### *Incentive Reimbursement Experiment*

The Connecticut Hospital Association's Incentive Reimbursement Experiment was the first such proposal to be approved and funded by the Social Security Administration. It became operational on May 1, 1969, with the hiring of the project director.

A brief background about Connecticut and CHA might be helpful in understanding the motivation of and progress in the program. Connecticut is a small state-one can drive from east to west or north to south in about an hour and a half or two hours. This has enabled personnel of the state's 35 not-for-profit general hospitals and some 20 long-term institutions to meet at least monthly to discuss common problems and new ideas. Through the CHA, all Connecticut hospitals have had a uniform accounting system, an established cost finding program, and a system of cost reimbursement for more than 20 years. Hospitals have shared detailed cost information among themselves through CHA for many years and this same information tradition-

ally has been shared with state agencies and interested third parties. In this climate of strong commitment to the state hospital association and a cooperative attitude toward change the incentive reimbursement experiment had a real opportunity for germination and maturation.

#### *Administrative Structure*

The experiment is operating under a four-year total budget of almost \$1,000,000, of which \$200,000 comes from Connecticut Blue Cross and the balance from the Social Security Administration. This sum will cover costs of hospital budget reviews for three fiscal years and costs incurred in original development and final evaluation. At present, the experiment has a central staff of five people—a project director, three project coordinators, and a secretary.

Eighteen short-term general hospitals—roughly half of those in the state—are participating in the incentive reimbursement program. These eighteen are divided according to size into three groups of six hospitals each. Our belief is that hospitals of similar size also are similar in their approaches to management, in the degree of necessary budget refinement, and in the degree of responsibility and authority given to assistants, controllers, and department heads. Each of these size groups is broken down into two divisions, which are composed of three hospitals each and represented by a budget approval board. The board, or peer review body, contains nine individuals—three administrators, three controllers, two directors of nursing, and one hospital trustee. Each budget approval board reviews only the budgets of hospitals in the other division of its size group. Under this system, no hospital has its own representatives reviewing its budget. We have been able in most cases to limit the duration of board sessions to one day. To spread review sessions out over a longer period would jeopardize the success of the experiment because hospitals soon would find the time constraints burdensome and almost certainly would withdraw from the program.

Each project coordinator has general responsibility for one size group. His duties involve consulting on budget problems, aiding in budget preparation, transmitting information about the experiment, staffing the budget approval board, and so on.

The separation of hospitals into size groupings has proven to be extremely effective. We have found that the hospitals of medium size, that

is between 150 and 350 beds have been challenged by the experiment. The budgeting process was familiar to them but it had not yet been used as an effective planning instrument. In the small hospitals of 150 beds and under the development was slower but they too saw value in the experiment and assimilated new ideas and concepts readily. Both groups have achieved some success with peer review but almost entirely in its value as an educational medium. As will be noted later, the value of peer review as a mechanism for final and binding budget decisions is questionable, in my opinion.

It is in the large hospitals where the experiment has run into substantial trouble. The problems have caused the termination of budget review in the third year for these hospitals. An effort is being made to study and hopefully resolve the issues. Whether the problems are related to technical objections to certain budget review tools such as flexible budgeting and systems engineering standards, whether it is a refusal to be arbitrary when approving budgets that is causing the difficulty or whether it is more basic than that—one of conservative attitude and behavior we don't know for certain at this time. I will speculate on these, however, later.

Overseeing the activities of the budget approval boards is a coordinating council consisting of 13 individuals—eight consumers, three representatives from hospitals not in the experiment, and two representatives from the contracting agencies involved in the funding. The role of the coordinating council is to review the actions of the budget approval boards with the following responsibilities in mind: to maintain uniformity of budget approval board decisions and actions and to maintain compliance with the experiment's guidelines. Judgments regarding budgets, rewards, and penalties are made exclusively by the budget approval boards.

#### *The Scope of Review*

We chose departmental budget review as the most effective way to control expenditures for a number of reasons. First, incentive reimbursement must be prospective in order to be effective, that is, reimbursable costs must be agreed upon before the costs are incurred. Second, per diem target rates and global budget review were considered inappropriate in the beginning because they contain costs over which the hospi-

tal administration exercised little or no control. For example, costs in departments such as laboratory, radiology, anesthesiology, and surgery are largely determined by the number of tests or examinations ordered by physicians or by the direct service rendered by private physicians. It was believed that a departmental budget system could absorb these departments after the basic concepts of review had been tested on more manageable cost centers. Third, because many hospitals in Connecticut already had budgets in varying degrees of sophistication, educating them simply to know and predict their costs would not be a massive undertaking. Fourth, we wanted the department head to be much more involved in the financial aspects of their hospitals, and to have the responsibility and authority to prepare departmental goals and expenditures.

After making the decision to use departmental budget review, we selected the departments to be reviewed the first year. These were house-keeping, laundry and linen, medical records, and nursing service (medical and surgical). These represent about 28 percent of total operating costs. At the same time, we decided to include the following departments the second year: administration and general, dietary, plant operation, repairs and maintenance, and pharmacy. In the third year, operating room, recovery room, radiology, laboratory, and anesthesiology were added for selected hospitals. Taken together, these departments approximate 85 percent of the hospitals' total costs. With the exception of nursing service, all departments included in the first two years were those over which hospital administration exercised the greatest degree of control.

In retrospect, the approach of using departmental review was a wise one. We are just now reaching a point where effective review by exception is taking place. By the use of internally and externally developed standards of costs and production, a screening mechanism can be developed which separates the line items which can be reviewed most productively and are likely to contain a high probability of payoff.

One unique aspect of our experiment is our commitment to approval of budgets, rewards, and penalties by peer review. This procedure was chosen to test the notion that efficiency and maximized services can be achieved by hospital professionals working together through self-regulation and self-discipline, and without interference by contracting agencies, governmental

bodies, or ad hoc commissions. Undoubtedly this is the most difficult aspect of our experiment to implement because it entails heavy investment of time by administrators, controllers, and department managers. It involves the development of progressively more streamlined techniques in order to review hospital budgets as quickly as possible yet accurately and completely. We believe that no one knows more about the problems associated with hospital management than hospital managers, and that no one knows more about hospital efficiency than hospital managers equipped with the tools of systems engineering. If these experts can be properly motivated to be objective and critical, yet introspective and tolerant of inherent difficulties in the system, no one will be better equipped to handle the task of budget review.

The motivational issues will be discussed shortly. I would like to at this point, however, make some observations on the peer review approach to setting hospital budgets. With the general qualifications that we, of course, were dealing with a specific environment; a small group of singular individuals and a certain predetermined methodology, albeit somewhat flexible, peer review is not very effective. Most hospitals in the experiment have asked for third-party involvement so that they can be persuaded to make difficult decisions-without all the facts.

I don't wish to do an injustice to a few well documented examples where a stiff backbone and stern judgment prevailed. It is just that, in the aggregate, hospitals refused to be arbitrary with one another. I think that it is on this one point that peer review is likely to fail. One must get used to the idea that in a budget approval process, by its very nature, all facts cannot be known. Wages are estimated, especially where union contracts exist, volume of services and census are estimated, new programs are estimated both as to actual implementation and starting date, departmental turnover is estimated, ability to make staff reductions in cost centers which appear to have excessive personnel are estimated and so forth. With so many unknowns it is only reasonable to expect that hospital administrators and financial officers, who after all experience the same problems of estimation themselves, will either decide to approve the budget as submitted or agree to adjust difficult to measure budgeted costs at year end to actual expenses thereby creating a retrospective reimbursement system. In order to make a prospective budget review system

effective, best judgments must be made no matter how arbitrary. This, of course, flies in the face of fairness and equity, but a determination must be made at the outset as to direction on this issue. Under a prospective system, the more reopeners that exist for allowable volume changes and cost increases or decreases which are ostensibly beyond the control of hospital management the more it begins to look like a retrospective system.

Kermit Gordon has noted that "equity and simplicity are mortal enemies." The more standards that are used, the more formulas that are imposed, the more arbitrary budget review becomes, the greater the risks that hospitals will not be treated fairly and equitably. It is a sensitive balance that is not easily achieved.

Another reason why peer review has not been completely successful is that some hospital executives, I think, only operate effectively under a mandated system. After the rules of the game are determined and the playing field defined these individuals can maximize reimbursement better than most others. But when the opportunity is given to sit on the rules committee and to promulgate the field dimensions, they often lose the ability to cope. In the peer review system which was envisioned by the experiment most of the groundrules were to be made by the hospitals themselves. It was not easy for some to comprehend this freedom of decision.

One final problem of budget review by peers is the pragmatic concern of time constraints. Despite our efforts to streamline budget review using exception techniques and other time conserving methods, attendance at Budget Approval Board meetings is irregular. Administrators, in particular, have commitments and priorities that compete with Approval Board Sessions.

### *Rewards and Penalties*

Motivation has many facets. Obviously the principal motivation that was being tested was the reward incentive. Would not-for-profit hospitals see the experiment as an opportunity to derive additional funds, that is over and above operating costs, for the hospital?

Our general philosophy on rewards is that, first, there should be a flexible reward system and, second, rewards should be achievable and desirable, but neither expected nor automatic.

Similarly, we believe that penalties should be stringent enough to provoke necessary actions

but not so severe that a hospital risks insolvency or that inequitable treatment occurs. The science of cost comparisons is not yet sophisticated enough, and the predictability of hospital costs, census, or departmental work volumes not absolute enough, to deny a hospital its operating costs because of alleged inefficiencies. Dr. Richard Elnicki, former assistant professor of economics at Yale University (now with the department of business administration of the University of Florida) has demonstrated in a study using multiple regression that 40 percent of the cost variations among Connecticut hospitals can be accounted for by above-average wages, above-average nursing hours, and above-average consumption of special services. A penalty formula denying reimbursement for these factors would have no effect on a hospital with lower-than-average wages, lower nursing hours, and lower special service consumption, but, in fact, is inefficient.

Our philosophy, then, is that penalties should be imposed only in areas that do not affect operating expenses such as plant capital, working capital, and so on. Denying reimbursement because of alleged inefficiency in these areas would jeopardize a hospital's financial position enough to cause it to act in the desired manner, yet would not penalize it inequitably for the inability to predict costs or the inapplicability of cost comparisons with other institutions.

There is no penalty insofar as Medicare is concerned; however, there is a potential penalty in Blue Cross reimbursement. In the Blue Cross contract in Connecticut, financial requirements for expansion, working capital, and so forth are covered by a 5 percent growth and development factor. A hospital whose aggregate actual costs exceed the aggregate adjusted target budgets could lose up to 2 percent of that 5 percent factor.

Our reward formula operates as follows. At year's end a hospital would be reimbursed for the aggregate total expenses of all departments or for the aggregate total of adjusted target budgets, whichever is higher. The budget is adjusted for actual departmental volume experienced during the year and for occurrences (such as union contract demands in excess of what could have been anticipated and untimely breakdown of equipment) that the budget approval board is convinced were out of the control of the hospital.

I think it is now fair to say that with a few exceptions not-for-profit hospitals are not motivated by rewards at least in the way we are applying them. The smaller hospitals appear to have been most influenced by the idea of a reward. The reward seeking seems to vary inversely with the hospital's size. Possibly, a more personal reward system such as one which would designate a certain percentage of the reward, such as 25 percent with an upper maximum going to the chief administrative officer with another 25 percent being distributed by the administration to key staff individuals might have more influence. I suspect, however, that this idea would be anathema to individuals who would be concerned about medical staff reaction or with the paradoxical relationship this would have to the net-for-profit philosophy.

It is my belief that not-for-profit hospitals will provide the maximum amount of services possible given the available financial resources. If a reduction in costs can be accomplished in one area the available working capital will be used to increase and improve services in another.

Another motivation might be that of the threat of government intervention if nothing is accomplished voluntarily. I think that this risk was not imminent in Connecticut during the period of the experiment nor was the experiment looked upon by State legislators as a substitute for more rigorous controls on hospital expansion and rates. The peer review approach might have worked better in a different environment.

### *Industrial Engineering*

The expectancy level is a vital component in the experiment. Essentially, it is an effort to avoid comparison between hospitals based on size, geography, service, or other factors that are largely uncontrollable by administration yet influence costs to an enormous degree.

The expectancy level is the number of productive hours required to perform adequately the tasks necessary to achieve a given production volume in a department. For example, in the laundry department the expectancy level would be the number of productive hours required to produce a certain number of laundry pounds, given that particular laundry's configuration of equipment, space requirements, and functions. The expectancy levels serve a number of purposes.

First, they are a guide or goal for hospitals in staffing each department. The expectancy level tells the hospital merely that a particular

staffing level is achievable, not how to achieve it. Therefore, it is the hospital's responsibility to determine ways to control any excess hours and to accomplish proper staffing levels.

Second, it is a tool with which the budget approval boards review a hospital's budget. A budget that anticipates hours of production that would move a hospital away from its expectancy level would be viewed rather critically by the peer review group.

These expectancy levels are produced for the experiment by two organizations—Community Systems Foundation and Peat, Marwick & Mitchell. The CSF expectancy levels are developed by traditional industrial engineering approaches through the use of predetermined standards. The Peat, Marwick & Mitchell methods use a self-logging technique wherein the standards are developed uniquely for each hospital. Without getting into the comparative accuracy of each method, I think it is fair to say that the self-logging approach has greater acceptability for purposes of peer review.

### *Evaluation*

SSA has contracted with Yale University to evaluate the Connecticut experiment. The evaluation will be carried out in three different areas: first, the characteristics and effectiveness of the interaction of the peer group itself; second, the measurement of how this group action has changed the cost experience of the participating hospitals; and, third, the monitoring of selected parameters of patient care patterns in selected hospitals.

The department of epidemiology and public health is acting as the master contractor in the evaluation of the experiment and the evaluation of the peer review concept is being carried out by the department of administrative sciences. An observer from this department either attends in person or hears tapes of all budget approval board meetings in an attempt to learn whether problem solving and decision making is sincere, honest, and critical, or represents nothing more than mutual backscratching.

The second factor to be evaluated is the effect of the experiment on the cost of participating hospitals. Obviously, the goal of any incentive reimbursement program is to moderate cost increases in hospitals. If the experiment fails on this account, it seems unlikely that the idea of incentives, or at least the Connecticut approach to them, would be an acceptable way of financing health care in the future. This area

will be evaluated by Dr. Richard Elnicki. It will be measured in two ways. First, the cost experiences of the 18 participating hospitals during the past ten years have been projected over the three years of the experiment. Actual costs will be plotted against this line and the differences measured. Second, the cost experiences of the 17 hospitals not in the experiment will be developed and compared in the same way. By comparing the experimenting hospitals with this control group; we will know that any deceleration of costs is a result of the experiment and not of industrywide changes in the normal trends of hospital costs.

The third area of evaluation is admittedly superficial. Yale, through a program called Basic Utilization Review Program (BURP), will measure changes in the length of stay of certain selected diagnostic groups subdivided by selective characteristics of either the patient or the treatment received in the hospital. This, of course, omits quality considerations such as the number of times linen is changed or the excellence of a meal. However, our working hypothesis has been that, because all hospitals in Connecticut are accredited by JCAH and comply with state licensing standards and because no experimenting hospital can be reimbursed for less than its operating costs, no administrator or board of trustees will sacrifice the essential quality of its institution for the purpose of receiving a reward.

### *Conclusion*

In conclusion, I must say that there are some large obstacles in incentive reimbursement or prospective reimbursement using the budget review, cost based mechanism. If the system is equitable and responsive to the differing needs of hospitals, it is likely to be ineffective in saving significant amounts of money or in achieving the predictability and risk sharing that everyone seems to be after. Administrative costs are high if a truly responsible job of budget review is undertaken. While I don't believe that the problems which I have mentioned are insurmountable one must examine them compared to the potential advantages to be gained.

At least in Connecticut, if we in the future consummate a prospective reimbursement system, problems will have been brought out during the courtship through implementation so that the result may be an informed marriage.

CHAIRMAN MAY: Thank you, Dennis. I think

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there are some interesting contrasts between the Connecticut and New Jersey programs that we probably should look at this afternoon.

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Larry Hill, who is Vice-President of Rhode Island Hospital, Providence, is our final speaker this morning. The distinction which he carries in my mind is that he is one of the few people in our field who manages to be a great man without looking like one.

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MR. LAWRENCE A. HILL: I want to think about that.

"Prospective Rating in Rhode Island" or "The Battle of Little Rhody." I was once told by Jim Hamilton in Minnesota that the hospital administrator (condescendingly referred to in the academic world as "the practitioner") was useful in the academic arena, not as a real teacher, but only to tell war stories. It is comforting to me that my assignment today involves a description of a program taking place in Rhode Island. This is not, therefore, an attempt by the practitioner to delve into the realm of academic theory, but clearly the telling of a war story. Further, the war is not over, so I can describe battles already fought and outline battles to be fought. And I sincerely believe I can identify the winner. He is the consumer of hospital services in Rhode Island.

### *The Beginnings*

In the beginning were rapidly rising hospital costs and a rapidly rising clamor about them. It was clear to anyone who cared to look around him that some form of control was coming. Uncontrolled retrospective cost reimbursement could not survive for long in the Rhode Island political climate. In Rhode Island, all hospital fiscal years commence October 1. Budgets are put together in the Spring and Summer. Under the old system, budget estimates were given to Blue Cross (which covers approximately 85 percent of the population) so that it could calculate premium rates and file with the State Department of Business Regulation for increases. Each filing, naturally was accompanied by a barbaric (and totally useless) rite called a public hearing.

In the spring of 1970 the management of Rhode Island Hospital proposed to its Board that the hospital negotiate its budget with Blue Cross in advance of October 1, to share savings with

Blue Cross and to accept all losses. The Board agreed. The hospital then proposed to the state hospital association that the negotiations be made a pilot project. The association agreed. The proposal was taken to Blue Cross and Blue Cross agreed.

No one really knew how to go about this, but the decision was to do it anyway. Social Security was asked if it wished to join in the venture but it could not because our approach did not meet SSA guidelines regarding measurement and evaluation.

### *The First Year*

A series of discussions between the Rhode Island Hospital and Blue Cross held during the spring of 1970 served to produce the framework of the agreement and the process of negotiating. The results were astonishingly simple. The agreement was as follows:

The hospital Service Corporation of Rhode Island, known as Rhode Island Blue Cross, and the Rhode Island Hospital hereby agree to an amendment to the Rhode Island Blue Cross Member Hospital Contract of October 1, 1966, with the following provisions:

1. The agreement will be in force for one year, beginning October 1, 1970.
2. Reimbursement for inpatients will be as follows:
  - A. *Semi-Private Contracts*
    1. Routine care reimbursement will be on a per diem or daily basis.
    2. Ancillary services reimbursement will be on a Ratio of Costs to Charges basis, with the hospital guaranteeing unit prices.
  3. *Reimbursement for Outpatients*

Outpatient minor surgery visits and accident room visits will be reimbursed on the basis of overall costs paid on monthly basis. Outpatient ancillary services will be paid on the same basis and with the same guarantees as inpatient ancillaries.
4. The hospital agrees not to increase prices for any ancillary services for the life of the agreement. In addition, it agrees to negotiate a range of utilization both upwards and downwards, and if actual use violates this range in either direction, the question of reimbursement for ancillary services will be reopened at the request of either party.
5. Rates as agreed on will remain in force for one year. These rates, however, may be subject to review and change within the year in the event of unforeseen circumstances causing an inordinate effect on either party. A request for relief by either party will be acted upon promptly, and any resultant change in rates will be negotiated with an effective date retroactive to the date of the request.
6. Reimbursement to the hospital shall be based on prospective rates agreed to, and will not be subject to year-end cost settlement. The hospital, however, will make available to Blue Cross a copy of its annual budget, Micah Cost Report and year-end audited statements for the purpose of determining gains or losses which may have resulted.

7. The hospital shall assume the risk for any losses over established rates. In the event of hospital gains, Blue Cross will share the balance on a 50-50 percent basis with Rhode Island Hospital.
8. All experience gained in the negotiating process and in the administration of the agreement will be shared mutually by the hospital and Blue Cross with other members of the Hospital Association of Rhode Island.
9. This agreement is an amendment to the present Blue Cross Member Hospital Contract now in effect. Both parties agree to honor the provisions in the contract. If interpretation of this amendment cannot be agreed upon by the signatories, the matter will be submitted for arbitration to a three-member committee, consisting of one member appointed by Blue Cross, one by Rhode Island Hospital and the third appointed by the first two.

Once the agreement was reached, it merely remained to carry it out. Because the hospital's budget is detailed and complicated and because Blue Cross had never before analysed one, Blue Cross representatives spent weeks with our accounting department during budget preparations. After the budget was reviewed by the hospital's Board of Trustees, it was submitted to Blue Cross for analysis. When their analysis was completed, Blue Cross notified the hospital and negotiating sessions began. The first session was held with Blue Cross requesting the hospital to cut something over one million dollars from its budget. Our total was about \$38 million. In succeeding sessions various kinds of proposals and counter-proposals were made. It would be less than candid not to say that a certain amount of heat was generated on both sides. At any rate, agreement was reached and Rhode Island Hospital agreed to reduce its proposed budget by \$950,000. Of this amount, \$520,000 represented new or expanded programs which simply were not undertaken. The remaining \$430,000 was money which the hospital simply had to save through more efficient operation.

This agreement was reached at a time during which public hearings regarding a Blue Cross rate increase were underway. The news of the agreement made front page headlines and struck the hearings like a bombshell. The result was that all of the other hospitals in the state offered to guarantee Blue Cross that they would not exceed their budgets during the coming fiscal year (although it was too late for them to negotiate individually) provided Blue Cross would agree to a 50-50 percent split in savings. Further it was stipulated that all hospitals would negotiate budgets the following year. Blue Cross agreed and state-wide prospective rating was underway. Incidentally, Blue Cross got about two-thirds of its requested increase.



## *The Second Year*

Negotiations with one hospital is one thing, but to do the same for all fifteen hospitals in the state was clearly something else. Thus, committees from Blue Cross and the Hospital Association immediately began work in an attempt to design a uniform and workable process within which negotiations could take place. In addition it was clear that prospective rating fundamentally changed the nature of the Hospital-Blue Cross Contract and that this should be looked at also.

At this point a new and complicating factor entered the arena. State government, in the form of legislative interests, expressed great concern with rising hospital costs and a bill was introduced into the legislature which would have given the State Department of Business Regulation (the insurance commissioner) the right to set hospital rates. Aside from the obvious hospital objections to such a plan it was also obvious that this kind of regulation spelled the demise of prospective rating. Therefore, the Hospital Association and Blue Cross began working through the legislative process and managed to secure passage of a substitute bill which, in effect, makes the state through its Budget office a party to hospital-Blue Cross negotiations. Thus, beginning in 1972 the state, through its budget office, will participate in the negotiations and will have a direct voice in setting hospital rates.

During the second year, however, the state was not involved in negotiations except as an observer. The bill passed the legislature but not in time for the state to actually participate, thus the second year's negotiations were solely between hospitals and Blue Cross.

In considering upcoming negotiations, all the hospitals felt that some mechanism of peer review would be helpful before hospital budgets were sent to Blue Cross. It was expected that peer review would give each hospital an opportunity to rehearse its proposal, to uncover errors, to answer questions, and also to provide an opportunity for all of the hospitals in the state to have some understanding of what the other hospitals were doing. Panels of hospital administrators, controllers, and trustees were set up and these panels were assigned several hospitals each. Budget materials were submitted to the panels and meetings were held in which the hospital made its presentation to the panel. Questions were asked and advice given. The panels, of course, could not make decisions nor binding recommendations. It is interesting to note, how-

ever, that there were several significant changes in budgets made as a result of these peer review activities.

Once peer review was completed the hospital submitted its budget, revised or not as it saw fit, to Blue Cross. Budget submissions were made on forms designed jointly by hospitals and Blue Cross and incidentally which proved to be less usable than anticipated. Negotiations during this second year were more stylized than was the Rhode Island Hospital first-year experience. The first session consisted of the hospital's presentation of its budget and reasons for increase with Blue Cross listening and asking questions. No attempt was made to go an inch beyond that point. The second session consisted of a Blue Cross counter-proposal. In this session, Blue Cross described the budget to which it would agree without further discussion. In most cases it actually detailed those budget items which it wished to see deleted. By and large, hospitals at this session merely listened and asked questions. The third session was the hospital's counter to the Blue Cross proposal and by this time the negotiation was getting down to serious business. In most instances (10) full agreement was reached between hospitals and Blue Cross, but there were five hospitals with which final agreement was not reached. The Blue Cross-Hospital Contract called for mediation and finally, binding arbitration. Everyone, however, was reluctant to go to arbitration and thus, a mediation step was designed.

Even before the impasse had been reached, it had become clear that some type of high level hospital-Blue Cross communication and understanding was needed. A liaison committee was established which consisted of four members of the Blue Cross Board plus three Blue Cross staff, four hospital trustees, two hospital administrators, and the Executive Director of the Hospital Association. It was to this group then, that points of disagreement were referred. This committee heard presentations by both Blue Cross and each of the hospitals where agreement had not been reached. They were empowered to recommend solutions but the recommendations had no binding authority. After hearing all of the arguments, this committee recommended that Blue Cross approve a small portion of the elements in contention. It recommended that it disapprove a larger portion and that the largest portion of all be submitted to the state's voluntary Health Planning Council.

In all cases the committee recommendations were accepted and arbitration was avoided.

According to the Blue Cross President, negotiations during this second year resulted in reduction of \$5,000,000 from the budgets of the state's hospitals.

The actual operating results for this year will not be known until the close of this fiscal year in September 1972. It is clear, however, that the negotiations have resulted in far more attention to budgets and to expenditures and controls than was previously the case. It was also true that the negotiations resulted in the lowest annual hospital cost increase in the past five years. It is also a fact that for the first time in a long time Blue Cross did not ask for a rate increase and, as a matter of fact, finished the year with growing reserves, where it had started the year in the red.

*The Third Year*

The third year is just in its beginnings. At this date hospitals have only begun the budgeting process. There will be, however, two new elements involved this year. The first of these has been mentioned already, i.e. the state government. Throughout the proceedings, they will be party to the negotiations. Just how this will work out no one yet seems to know. Obviously it will not make life any easier on the hospitals.

The second new element may well be far more fundamental. During the second year, Blue Cross found itself faced with making decisions to finance certain medically-related programs and refusing to finance others. It felt that while it was prepared and responsible for financial decisions, it could not set medical priorities for the state. Blue Cross, therefore, sent a letter requesting that all hospitals call a one-year moratorium on implementing any new medically-orientated programs. Hospitals naturally refused. A series of meetings involving the previously mentioned liaison committee produced a process which, to my knowledge, is unique in the United States. In this process, hospitals planning new or expanded medically-related programs must submit the plans to the Health Planning Council (the community's voluntary area-wide hospital planning council) for review. The Planning Council will review all program plans and place them in one of three priority slots. The first, or Priority I is titled, "Implementation or Expansion Encouraged this Fiscal Year"; Priority II, "Implementation or Expansion

Not Encouraged for this Fiscal Year"; Priority III, "Implementation or Expansion Not Encouraged at All." The programs which must be submitted to the planning council are medical programs as opposed to non-medical such as expansion of a medical record library or dietary kitchen, etc. Medical programs which have multi-hospital implications must be submitted to the planning council regardless of the amount of money involved (this is especially important in Rhode Island because five hospitals are affiliated with Brown University's developing medical school). Medical programs which are not multi-hospital in nature must be submitted if total amounts exceed certain limits. These are as follows:

	<i>Hospital Budget</i>	<i>Annualized Program Cost</i>
Group I . . . . .	\$15 Million and above	\$100,000
Group II . . . . .	\$10-15 Million	\$ 75,000
Group III . . . . .	\$5-10 Million	\$ 50,000
Group IV . . . . .	\$5 Million or below	\$ 25,000

While franchising for capital expenditures is not new (and does exist in Rhode Island), the hospital's obligation to submit program development even where no capital expenditure is involved to a planning council, is new. This is not a statutory type of requirement. This was agreed to by the hospitals in the state voluntarily with Blue Cross.

This, then, is where we stand currently in Rhode Island as we enter our third year of Prospective Reimbursement.

*Federal Guidelines*

Thus far I have said nothing concerning Phase II and Wage and Price Freezes. This element filters throughout all of our efforts, but because of the uncertainties involved it seemed better to approach this subject separately rather than try to thread it into the chronological account. It is quite clear that if wage and price controls are continued as they now exist, prospective rating simply is not feasible in the manner in which we have undertaken it. It is impossible for the hospitals to conform to two sets of simultaneous but different sets of controls. Therefore, the State Hospital Association and Blue Cross have applied to the Price Commission for exclusion from the federal guidelines. As of this date, word from Washington is encouraging but as yet "informal."

Whatever exclusion is granted (if granted) it will apply only to our current fiscal year which ends September 1972, thus we are uncertain as to what will happen in the future. Nevertheless, we feel that the only option is to continue to pursue the path of Prospective Reimbursement until intervening forces make it impossible. (The uncertainty of these controls and the way it is worked out reminds me of the story about the man sitting in the control tower at the airport. A voice came over the microphone, "Can you tell me what time it is?" The control tower man said, "Identify yourself." "I only wanted to know what time it is." "Well, if you are with a domestic air line like United or American, I would say four o'clock. If you are with KLM or BOAC I would say 1600 hours." "I understand," said the voice. "I am flying Air Force 1, and I have the President and some members of Congress aboard." "In that case, sir, the big hand is on 12 and the little hand is on 4.")

#### Summary

To summarize then, all of the hospitals in Rhode Island are currently engaging in a plan of Prospective Reimbursement which has the following key characteristics:

1. Hospital budgets are prepared in advance and submitted to Blue Cross and state government.
2. Hospital plans for new or expanded medically related programs are submitted in advance to the Health Planning Council which determines priorities and submits its recommendations to Blue Cross and to the State.
3. Once all hospital budgets and plans are received, negotiations on a one-to-one basis proceed.
4. Once agreement is reached, hospitals cannot be paid more than the budget calls for and will share savings with Blue Cross on a negotiated basis. This has been 50-50, but is subject to change.

Results to date would indicate that there are savings to be achieved, both in the planning and negotiation processes themselves, and in more acute attention by management to internal operations. Evidence offered is that the state's hospitals collectively finished the first year of prospective rating under budget, and second-year negotiations resulted in reductions of hospital budgets by \$5,000,000.

#### Comments

Prospective Reimbursement in Rhode Island is causing fundamental changes in hospital governance. For the first time, an outside party has a direct voice in the approval of hospital expenditures before the fact. For the first time, an outside party has a direct voice in which programs a hospital will or will not offer to the public. These are giant steps for hospitals and trustees to take. These steps are being taken, quite frankly, because hospital boards are convinced that the only alternative would be legislative controls which probably would be even less tolerable. From the administrator's point of view, the process is increasingly complicated and time consuming. It demands far more advanced planning and budgeting and far tighter controls on expenses. Neither of these elements is designed to enhance an administrator's popularity with physicians or employees.

It is also fair to say that the objective in mind is an economic one. Hospitals, as well as Blue Cross, have become convinced that the upward spiral in costs simply had to be retarded. I have described the procedure devised in one small state to achieve that objective. The returns are not all in, but fragmentary evidence would indicate some success. The majority of the battles lie ahead in this war story. So far the consumer has won economically and there is no perceptible adverse influence on quality as yet. Obviously the long-run results depend on the skill, vision and philosophies of all parties involved. Optimistically, a balance between economic concerns and medical care concerns will occur and some sort of peace treaty, or truce, or demilitarized zone will result. This war and these battles, however, are benign; all parties have survived, and if we display sufficient wisdom they all should emerge strengthened.

CHAIRMAN MAY: Thank you, Larry.

I think what we have heard this morning is sort of the anatomy of what is going on. This afternoon I hope we can get more into the physiology.

## PANEL DISCUSSION

### Prospective Budgeting

JOEL MAY, *Moderator*

*Panel members:*

HAROLD HINDERER, *Controller of the Daughters of Charity Shared Services, St. Louis, Missouri.*

JACK W. OWEN, *President, New Jersey Hospital Association.*

LAWRENCE A. HILL, *Vice-President, Rhode Island Hospital, Providence, Rhode Island.*

DENNIS P. MAY, *Director of Finance, Connecticut Hospital Association.*

CHAIRMAN MAY: May we start with some of the questions for Harold Hinderer's speech.

MR. REED REYNOLDS [Gary, Indiana]: The idea of market place assumes that the individual is going to have completely free choice. I think that is one of the conditions of free enterprise. I don't think that is realistic with today's physicians, and so on.

MR. HINDERER: I don't think the patient has free choice in exactly the way we like to think about it. The patient does have the ability to evaluate alternatives. The patient does have the ability then to bring pressure to bear upon the doctor.

I think the field experience has been that with many of the middle-class blue-collar workers we don't have the same doctor loyalty that many of us seem to think exists. We have seen it in Milwaukee. In the COMPCARE that Blue Cross has set up we have found many people selecting the COMPCARE coverage, which is something akin to an HMO, and they have voluntarily chosen that. It means a new doctor. It means going to a new group. But if these people are assured of quality and assured of a lower impact on their pocket books, I for one am not convinced that there is not the potential of mobility within the patient ranks from doctor to doctor.

I also think that even if there is doctor loyalty, the doctors (being the kind of people they are) are going to get damned sick and tired of hearing

people complain, "How come I go to the hospital you go to, and I have to pay \$10 a day, when I go to Memorial Hospital and get the whole thing covered for nothing? Something must be wrong with the way you people are running that hospital."

REMARK: I think we have about half of the hospitals in the United States that still have 100 beds or less. I realize bed-wise that doesn't represent most of them, but it does represent a large number of hospitals that are in one hospital town away from metropolitan areas where there is another choice. I believe you will also find that these physicians don't have multiple hospital privileges. I would add to that also that they have a stronger control on the hospital's destiny. You might find metropolitan areas where there is an alternative. The only alternative is to go out of town. This represents probably 25 to 30 percent of the U.S. population who are subject to this. I think it is politically and economically a significant percentage. This formula, to me, seems to fall apart when you don't have the alternatives you have presented, using averages working with large numbers.

MR. HINDERER: Possibly so. Let us say we took the group of small hospitals. Let's say we took all the cornfield hospitals in the State of Kansas and had them split their bids as a group. I don't think we will find that much variance,

although I don't know. If the people in one town had to pay \$2 or \$2.50 a day because that hospital was that much above the average, I wonder if this might not be the price they have to pay to live there. They pay more for various manufactured items because of transportation costs and low volume. Maybe they have to pay more, but it is being compared to other people in like situations, and perhaps public pressure will be brought upon the doctors and consequently upon the administration of the hospital to do a more efficient job.

REMARK: I think this regards the way people live in small towns versus the way they live in metropolitan areas. I don't think you can measure Adam Smith economics in these areas. There is a stronger emotional overlay on decisions made here than there is in a larger city. Interpersonal relationships are entirely different.

MR. HINDERER: And that might make it even a stronger incentive to do the job. The fellow is in Bucks Corners, and somebody else is in Flatbed 30 miles away, and the people see that Flatbed people have a 50-bed hospital and don't have to pay anything for care in that hospital.

REMARK: Yes, but Ben Casey doesn't teach us this. Our only clutch with these areas is TV, and we see an awful lot of fiction about the health field.

MR. HINDERER: The Secretary might publish a list of all the cornfield hospitals and how much you have to pay in each one of them.

MR. HILL: I am not so worried about the buyer. I am not really convinced that even if he had a choice he necessarily would make the most economic choice. Nobody reads Consumers Union anyway. The thing that worries me is not that it is Adam Smith, but that it is not Adam Smith. As I remember the definition of a free market, one of the real characteristics is that no one individual actor in the market can, by his own actions, influence the market. We have one seller or one contractor really in this scheme, who is the Secretary. If he is the only one who is making up the specifications and accepting all the bids, then it doesn't seem to me we have a free market at all.

QUESTION: That was related to my question. I wonder if Harold would speak about the free

market, because that was one of your basic assumptions. What is your concept of a free market, and do you really feel it is working in this country? Not just in health care, but there are other constraints, legislative and otherwise, that seems to me prevent having a truly free market.

MR. HINDERER: No question about that. We have to use the term "free market" in the context of today's economy.

QUESTION: Could you tell us what that is? I don't understand what you mean by that.

MR. HINDERER: Where in our particular case here, the consumer would have the ability to bring pressure of one kind or other, to voice his objections. Maybe nothing could be done, but to voice his objections; to let his dissatisfaction be known. That may be the closest we can come in an area where there is one provider of care.

QUESTION: But they can voice that now, because they have a number of options and alternatives. You can go Blue Cross or White Cross or Gold Cross or Kaiser or anything. You have that option right now, as a provider or as a purchaser; right?

MR. HINDERER: Do you really?

REMARK: Sure you do. Does somebody tell you that you have to buy Blue Cross or Kaiser? I don't think so.

MR. HINDERER: No; so he has his free choice, and he will select the one he feels he gets the greatest return from.

QUESTION: The other question I want to ask, because it has a basic assumption, is that you said all care is paid for. Everybody here knows all care is not paid for. A specific example has been promulgated by HEW, that 5 percent will not be paid for. How do you plug that into your thesis?

MR. HINDERER: I have to make the assumption that at some time in the not too distant future, health care will be available to all people, and that those who cannot pay for it—the state and society as a whole will assume its obligation.

I have to make that assumption for this total picture.

QUESTION: I think you made another assumption, and that is the constancy of diagnosis and volume within the hospital, which of course cannot be predicted unless—I think it was Connecticut that has a very tight hospital bed situation. Would it be wiser to try this model out in the skilled nursing home facility where there is a constancy of volume, where we currently do have regulations permitting experiments?

MR. HINDERER: I don't think there is any question that the skilled nursing home would be an excellent place to start. It would be a much easier place to start, and it would be one very subject to measurement, to quite a high degree of exactitude in measurement.

But let me say one thing here. When we talk about these differences that we have in degree of care and intensity of care, and so on, many of these things we are measuring after the fact now. We are measuring cost per patient day. We are measuring cost per this, cost per that—after the fact. We certainly have a statistical base that is available to us so that we should be able to project for the future.

QUESTION: Assuming the future is the same as the present?

MR. HINDERER: That is one of the risks that has to be taken in a free market.

REMARK: It seems to me that the outcome of your plan is a multi-class system of care. This is economically desirable, but I think politically unacceptable at this time.

MR. HINDERER: Well, that may well be, but I was starting with what I would call the expressed public policy as written by the Ways and Means Committee. The Ways and Means Committee, in what I read you from its report, provides for this very thing. I was merely building on that, and taking this proposal of the Ways and Means Committee a step farther.

QUESTION: Do you think their proposal is acceptable in the political arena? If in fact all publicly supported patients are getting minimal care, and middle-class and wealthier patients are purchasing a lot of amenities that the publicly

supported patients won't be allowed to have—

MR. HINDERER: I would have very serious doubts about that. I think we have seen it in education. I personally would have doubts about whether or not the wealthy would be allowed to buy better care than poorer people.

REMARK: In their statement they said that they would not prohibit anyone from purchasing the amenities they wanted.

MR. HINDERER: And I based it starting from that. Then I went farther.

REMARK: I would consider that health care is one important component of hospital structure. We are very much concerned about efficient and low-cost health care so that the population movements across the nation take less advantage of metropolitan growth. Any time any competent person can get things more expensive than another, then there is reason for concern.

To what extent we can make hospital care and health care less expensive, fine. When we talk about transportation, about education, about any other component, even housing, then we have raised issues of standards, issues of low cost, efficiency, and all that. If we consider all those issues, I think the hospitals should accept all those constraints and controls which are being talked about for the recipients. At the moment, in education, it is said we should pay for education—that it should be nationalized. Mass transportation has been talked about; and that we should pay for it so that it will be cheaper.

If we are talking about hospital recipients and raising issues, in housing we set performance standards for builders. If we can accept other things, talking about hospital care and physician-patient relationship, and some sort of approaches, I think the time has come to change it.

MR. HILL: I think these kinds of things would all be very possible, provided that along with it goes a definition of what kind of standard we are willing to accept. A mass transportation system where the average waiting time for a bus is 20 minutes is quite different from a system where the average waiting time is five minutes. I would assume that the five-minute system

would be much more expensive. A housing system where every unit is a single-family unit, with X square feet of land surrounding it, is quite different from multistory housing.

Once we define standards, and if the public says, "We are willing to put up with X number of operating rooms per 100,000 people; we are willing to put up with this number of beds; we are willing to put up with a 10-week waiting period for admission to the hospital"—once those kinds of things are defined, then I think you can make these kinds of judgments. I suppose it is where the priority is set. One would be to set the amount of money one is willing to spend as a society, and then say what we can get for that amount of money. I think we have done it quite the reverse, and have said this is the kind of standard we are interested in, or we think we are, or we have been told we should be, and therefore it takes this kind of money to produce it.

I am not arguing against being more efficient or trying to rationalize the system, but I do believe that one cannot divorce a standard of performance and care from controls. This is where I guess I would fight with a lot of what I hear coming out of Washington. There is great talk about controls, with an almost hilarious absence of concern for standards, really.

MR. OWEN: May I comment on that, too. One of the things with this bus situation and housing that is different in the health care field is the if the people were paying through a third party or somebody else responsible for paying that bus fare, they would want a bus every five minutes, not every 20 minutes. This is what is happening in health care. The people themselves who are using health care aren't really paying out the dollars. They don't see it.

I think this is one of our major problems, because the people themselves aren't involved. Even in Harold's plan it is not the people who are saying what it is—it is the Secretary or somebody else who is going to do the bidding, and there is a different kind of market.

MR. HINDERER: Except, Jack, that if the Secretary sets standards on here, which would be considered after proper consultation—advisory panels, and so on—of the standards and then the hospitals bid on these standards, then if people wanted higher standards they would have to pay out their own dollars to get the higher

standards, and they would make the decision then whether they want to trade dollars for a so-called increased quality. If they do, they would have the right to do it.

MR. OWEN: But that is not what is going to happen, Harold: They are going to say, "We want those higher standards; and you, Mr. Secretary, get them for us so we don't have to pay out the dollars," just like you are saying now for Blue Cross and the rest of them.

CHAIRMAN MAY: There is good precedent for that.

MR. HINDERER: All right. Then if the public pressure on the spokesmen of the public, the elected representatives, is such that standards are to be raised, we will bid on higher standards.

REMARK: I think these analogies are very different. At the risk of reiterating, I think one of the things we have to think about, too, is that the people who are sick are the ones who are most concerned with what they are getting, and what the standards are, and they are a very, very small percentage of the people who are going to pay the bill.

The thing that bothers me is that as it becomes a political issue, the politicians will respond to the point where the greatest public pressure is, and the greatest public pressure will be from the well people who at the moment are not sick. I think these are considerations that we have got to keep in mind when we draw analogies between the guys who are riding buses and guys doing other things. This is an entirely different ball game we are talking about.

MR. HINDERER: When we see (if the figures are right) the number of people who are hospitalized in a year's time, and multiply this by their immediate contacts, family and close friends, we have a rather large cross segment of the population.

REMARK: It is a transitory thing. It is a one-occasion sort of thing. Once the illness is over and is taken care of, it isn't a constant day-to-day problem.

MR. HINDERER: Well, the family man with

a wife and four children and close relatives—I would question whether it is just a very episodic thing, or whether when we take this close circle of friends it doesn't become more periodic than episodic.

REMARK: I think your implication is that there should be more money if we want to impose standards. In terms of gross national product, every year we are spending much more. We cannot deny the fact that the nation is spending much more in terms of gross national product. The problem seems to lie somewhere else—not in providing more money but probably more rationality and more coordination and more planning, setting standards, expanding the public sector. The answer may be perhaps that the public sector should step in. In the European countries and the developing countries the system is getting to be just like that.

MR. HINDERER: In a completely state-controlled area, who sets the standards?

REMARK: The society itself.

MR. HINDERER: The state sets the standards. With a privately controlled system the state would set minimum standards, and then competition would work to raise those standards for the same number of dollars.

When we take the urban areas where there hasn't been health care provided, I think we have to ask, "Is this a fault of the hospital system, or is this a fault of lack of financing?" If there were financing to pay for the most efficient care, let's say, I find it hard to believe that somebody would not move in to meet that demand—to spread that need. I think the free economy can do it. I think the voluntary system can do it. If we see there is a need for health care in the ghetto area, and we know it is going to be financed within these limits, I think the ingenuity of the system will find a way to provide this care on an efficient basis.

REMARK: I want to propound a theory—that the reason we provide health services in a non-profit setting is because we want more than the free market will generate. That is the basic reason that we do it that way.

The thing that always worries me about trying to bring it back to the free market—and this has to do with this notion of efficiency—I have a notion that, in general, efficiency is not a tangi-

ble thing. Generally speaking, the hospitals that cost the least are the poorest hospitals. The better hospitals cost more.

I think any of us who have been in administration know how to get below that mean. There's no trick to it at all. Just cut the budget, that's all. It doesn't take a lot of wisdom. So, you have that problem, "I will see my way through."

The second problem is that if I get below that budget and I earn the bonus, what am I going to do with the money?

CHAIRMAN MAY: The consultants will tell you that.

REMARK: Let me put it this way: In the absence of some other provision, the only thing I can do with it is spend it, and there is no way to spend it without increasing the very cost that the program was designed to contain. It seems to me that somebody should pursue this line.

MR. HINDERER: First of all, we say there are objective standards. We also have the pressure of the medical profession, and we also have the pressures of the consuming public, which is a rather intelligent public as a whole. It is questionable how much cutting of quality the consumer would stand for, and especially how much the doctor would stand for.

What do we do with this additional money? One, we save it. We invest it. With a growing population we are able to provide the new services as they come, at a cost lower than it would take if we went out and debt-financed these facilities.

QUESTION: What if you are not growing?

MR. HINDERER: If you are not growing? Then I think we will find other areas in which to invest the funds.

REMARK: Plow it back next year, reducing your rate structure. I can tell Dick what to do with it. It's easy.

REMARK: Then you just generate more surplus.

MR. HINDERER: Is that bad?

REMARK: Instead of being \$2 below, you are above.



REMARK: No; you are only \$1 below, because you dropped your rate.

REMARK: I was thinking of one of the new standards of the Joint Commission, or at least the use of a new term in the new standards of the Joint Commission, "optimal achievable." A difference of opinion came to my attention last week. We were talking with some doctors. "Optimal achievable" to a doctor means an entirely different thing than it does to the finance committee and Jack's budget review. As far as they can see professionally, if it is achievable it is something they should have, and they have the capacity to arrive at it. The financing is an entirely different thing. It is your problem to find the money.

I remember when meals used to be almost a standard perquisite for your employees. You hired them and gave them meals as a part of their pay. Everybody was unhappy, and they complained constantly that the food was no good. Meals on a pay-as-you-go basis gave the people a right to pick what their optimal achievable limit was as far as going through the dietary market was concerned. Maybe a similar application can be made in the health field.

MR. HINDERER: Let me make one more comment. There would come a time when you would stop being lower, because you would have only the efficient operation left. You would get down so that just about everybody was operating on this mean, on this average—this weighted average—so that then there would be no more generation on there.

REMARK: But anybody can get lower than that.

MR. HINDERER: You still have your quality constraints.

REMARK: That's the problem. The word "efficiency" is an engineering term, and it means the difference between what goes in and what comes out. What we are talking about here is quantity measurement of things. It doesn't really amount to much when you are talking about efficiency. Some outfit generates 12 patient days a year. The fact that all people were sleeping in dirty sheets and eating cold food, and had no nursing at night, isn't reflected in that at all. It doesn't mean a thing until you put it in some context of quality. Quality is like beauty:

it's in the eyes of the beholder. What is good for you is bad for me.

It seems to me we have to be careful when we talk about efficiency, when we are relating an input which we can measure in terms of dollars, and an output on which nobody, in the absence of some organized setting, would agree. We don't know what constitutes the output. We will create an organization and it will just decide, and they will say, "This is good enough." So, it seems to me the idea of efficiency is very difficult to apply in a non-profit setting where you are putting out social services.

REMARK: I want to know what Dick means by "non-profit." This bothers me. We talk about non-profit. That is a legal term. If there are hospitals that don't have black figures at the end of the year, then something is wrong with their setup. They should have a financial profit at the end of the year, no matter what they do with it.

Dick, you currently have it, and you are currently plowing it back into next year's operation. This non-profit thing is a lot of nonsense that way.

REMARK: I will give you a one-sentence definition. "Non-profit" is a form of economic organization that is designed to maximize service, whereas "profit" is a form of organization that is designed to maximize economic return. That is the difference in two sentences.

QUESTION: I am somewhat worried, because I am led to understand that some part of the increases in health care costs are due to technology which some people think are better for the patient than not having it. How the hell do we get the hospitals off of it?

MR. HINDERER: How do we get them off? In Joel's introductory remarks this morning he mentioned what society wants, and that it will be up to society to make the cost-benefit analysis.

QUESTION: Do you think the first intensive care unit would be put in if they are all out, and who would have the guts to do it?

REMARK: Somebody who made a profit last year.

MR. HINDERER: I think very possibly someone who did, and someone in an area where the doctor convinced the patient that this was good, or the doctors insisted on it.

REMARK: The first one was unproven at that point.

MR. HINDERER: The hospital may itself then have to take a flier, and see.

REMARK: And charge his patients then a specific charge, because obviously that couldn't be filled in the first year.

MR. HINDERER: Or if the institution, Marty, is truly concerned about rendering this increased service, and it has funds from prior years. It will be the efficient ones that would use the accumulated funds from prior years, or it will be the hospital through its contributions, supplemental income, gift shop income, parking lot income, rental income; this type of thing. They will say, "All right. We have this money. We want to try this. We think this is good." Therefore, if it fulfills the true non-profit motivation, then it will be put in.

Many hospitals with these services—I can remember very well one of the first recovery rooms. It was in St. Joseph's in St. Paul, one of the first hospitals I worked in. This was put in with a charge on it, but there was a tremendous loss in there.

REMARK: But the loss was covered by the other patients.

MR. HINDERER: It was also covered by supplemental funds, Marty.

REMARK: If you can visualize that in your world, fine.

CHAIRMAN MAY: There is another aspect of this whole thing that bothered me this morning. It deals at two levels, first with the averaging we have always had trouble with, vis-a-vis hospital comparisons over time, and what implications this has for who is bearing the risk.

Implicit in what you are proposing, Harold, and explicitly avoided in what you are talking about, Jack, is the principle that if each hospital is going to stand on its own, somebody is going to be bearing the deviations from the mean or being out on the tail, or having an unusually good

or unusually bad year. If the hospitals are going to be averaged, then each hospital itself is going to have to bear this risk.

If you happen to be average, with a group of people that happen to do better than you did this year, you are going to be hurt. Conversely also. I wonder if the net effect of transferring this result to the hospitals is going to result in lower or higher costs for providing health care. I am going to build in a safety factor in my budget. I am going to worry about the possibility of falling 13.5 percent below what my patient days were, and I wonder if in the long run this might cause me to go up and up and up.

MR. HINDERER: If you build this in and I don't, Joel, this is going to pull the average down more, and you are going to be put in an unfavorable competitive position.

CHAIRMAN MAY: It all depends on the outcome, on whether you bet right and I bet wrong, or vice versa.

MR. HINDERER: Absolutely no question about it. I am going to take the risks of the market place.

MR. OWEN: Harold, I would like to pursue something with you for a little bit. Let's say what you are saying is possible. I still think the question is, What are we selling? Is it a day of care? Is it a case? Is it a test? This to me is the real issue of how you are going to be paid, no matter whether it is bid or however else it is done. The problem is that we really haven't defined what we are selling.

MR. HINDERER: Jack, for years before social security came along we sold care to Blue Cross (and we still do in many places) on a day of care. We know from our experience in the past what a day of care is. We know what went into that average day of care. We could do it on a day-of-care basis. We could do it on a percase basis. With a total HMO approach we could do it on a per-person basis. We could do it on an individual-unit basis. I think with Dave's suggestion of the skilled nursing homes, certainly we should be able to do it on a per-diem basis.

MR. OWEN: Let's go back to the proposal I put up for the other hospital. Once we determine that a hospital and its services are needed, why

don't we just sell it on the basis of the total expense of that institution? Why go through all the paper work that is required back and forth—cost accounting, auditing, and all the rest? Once we have approved that this hospital is to operate on this particular basis with these kinds of services, why even bother with days or services or units? That's it.

MR. HINDERER: Two things, Jack. First, who has determined that this hospital is needed? A rather small segment of society.

MR. OWEN: No. In my particular instance I am saying the State of New Jersey has decided it.

MR. HINDERER: Is it the State of New Jersey? How many people make up the State?

MR. OWEN: Eight million people.

MR. HINDERER: And they say that this hospital is needed? Again we come back to the point that the market place would determine whether or not a facility is needed, whether or not society as a whole is willing to pay for this new hospital, or whether society is going to say, "We will sit with what we have, and put up with the inconvenience, rather than part with the dollars."

QUESTION: Society isn't able too well in some cases to judge what they want until after the fact; and if they decide they would or would not like to have the hospital, but at the time they need it and the hospital is there, who is making that decision? We are looking at reality, not projections, here. You are making an assumption or the "state" is saying you don't need the hospital there. What about the people who need it?

MR. HINDERER: All right. If the people decide that they need a facility—let's say there can be a public manifestation of this will. Let's compare this with where they are not completely comparable but they are alike in many ways. Who decides whether a new school is needed, or whether we double-shift the students? The people have their choice.

REMARK: Excuse me. You can double-shift a student or you can increase a class size from 20 to 50, but you can't put two people in one bed.

QUESTION: Harold, how are you going to equalize long-term debt commitments and lease commitments, and things of this nature? One hospital might be in debt for \$20 million and another hospital might have all of its debts paid off.

MR. HINDERER: I think we will find that the ones that would really significantly be hurt by this are those that have had federal guarantees. I doubt very much whether we will see those who subjected themselves to the market place in borrowing money, with a significant problem. There may well have to be some kind of federal assistance, since the feds insured this for these who are already under what I consider some very illogical and irrational financing schemes in here. It probably has to be some kind of protection, and a waiver, if you will, of at least part of the consequences of this extremely high debt.

MR. OWEN: I don't see too much difference in what I have seen happening for a long time. I will give you a specific example.

In our municipalities and counties they have done it, maybe not as scientifically as you said, with bids, and so on. They have just said, "We will give you \$30 a day and you provide the care." What happens to the other \$35 or \$40 that is needed? The patient doesn't pay it. What is going to be different about this scheme, and what we have got in these particular cares where the government says they are going to give us \$20 a day for these kinds of services, "and if you come under it, fine; if you go over it you will have to collect from the patient." I don't see what is different from what we have been doing for a long time.

MR. HINDERER: Except that in this way the hospitals themselves will have established the acceptable rate, and that 50 percent of the facilities available will be available to the public at this rate.

QUESTION: You talked earlier about people willing to put up with an inconvenience, and then they really didn't want a facility. Somebody brought up a question about a needed facility, and that was your answer. Suppose people didn't want to put up with the inconvenience, but also did not have the wherewithal financially to cope

with it financially—in other words, start an institution of their own. How does your system deal with that?

MR. HINDERER: The kind of thing I would see if that if we are tight for facilities, instead of building the new 300-bed hospital, we would find a way to add whatever the needed beds were to an existing, established, efficiently operated institution.

QUESTION: That doesn't answer the question. Let's hypothesize that there are 20 million people in the country who have below \$3,000 family income. These people, let's say in West Virginia, don't have the wherewithal, whether they need a hospital or not, and they are inconvenienced by a lack of it. They don't have the wherewithall to do anything about it financially, and they form too small a group to exert pressure on the larger group of people who are not inconvenienced by their not having a hospital. How do you deal with that? This is what I am asking. It is a social question, not a question of dollars.

MR. HINDERER: All right. We go back to the assumption—the premise—that everyone will have the ability to pay for the established levels of care, whatever the quality criteria are—that everyone has this ability. That all health care will be financed, with a market, then, where health care can be financed. There is the financing. I can visualize the efficient operator, whether it be a chain or one institution not too far away—I can visualize that operator saying, "Here is a market that is available to me, and I will go in and meet that demand, and I should be able to do it on an efficient basis." If there is some reason why you can't do it, for some sociological reason, if it can't be done on that basis, then I think government would have to make the decision whether it will assume its social responsibility and perhaps pay the additional amount that is needed.

QUESTION: Harold, I wonder if I can go back to some of your earlier comments. You were talking about controls that you perceive in the near future under H.R. 1. You talked about the reasonably prudent and cost-conscious manager, and efficiency, and things like that. I am wondering where medical education fits in those controls in terms of the efficient and prudent manager. Then I wonder if the rest of the panel

would comment on negotiations under prospective rate reviews in terms of medical education funds.

MR. HINDERER: Two things: One, the medical education program would no longer have to bear any free service, because again we come back to the assumption that financing is available for all people.

QUESTION: I am not talking about your model. I am talking about the actual controls you foresee in H.R. 1. Are there any in there?

MR. HINDERER: No. I am sure if H.R. 1 went through the way it was, medical education costs would be considered at least for stipends and that type of thing. I have no idea what would be done as far as the free care is concerned. I would assume that if H.R. 1 went through, the teaching hospitals, under some definition of what a teaching hospital is, would have to be treated differently from the non-teaching hospitals. Under my model I don't think they would. I think they would have to compete equally with the non-teaching hospitals.

CHAIRMAN MAY: What happened in Connecticut presently?

MR. MAY: That was not a department we were dealing with, so we didn't consider medical education costs at all.

MR. OWEN: In our State, education was removed, as I mentioned earlier. Education was pulled out of the budget. However, we ran into a problem this past year, because we found a number of hospitals that felt they were going to be affiliated with the New Jersey College of Medicine and Dentistry as a starter, and we began to get a lot of hospitals that were putting a lot of full-time chiefs in for education reasons, not for house coverage. A committee made up of representatives primarily from the directors of medical education, some trustees, and from the New Jersey College of Medicine and Dentistry. There was a ceiling put on those hospitals which they questioned as to how much educational costs they were putting into their budget. They didn't say they wouldn't get it, because again it goes back to the Commissioner of Health of New Jersey who is responsible for approving educational programs. If the Commissioner of

Health approves it, then it will go through. There is a question when it reaches a certain level at this stage in the game.

MR. HILL: In Rhode Island this question is coming up, and very seriously. At the moment I think we have been hiding behind the fact that nobody can define what is an educational component of cost anyway. The only really visible part is the number of house officers available. After that it gets pretty foggy.

We raise the banner of quality and texture of care, and all that, and some of it we do with tongue in cheek, and some of it honestly. I think it is pretty clear, however, given precedents that are being set in other parts of the country, such as Cleveland, as I understand it, where Blue Cross has pretty much delineated the salary levels they will pay for house officers; and Mr. Dennenberg has said he won't pay for educational costs, or something of the sort.

We will have five hospitals associated with a university. Given the kind of setup we now have, it would seem to me that in the future this medical planning programming bit will take care of the educational component, in that the affiliated hospitals and the university will have to begin to plan ahead for the kind of programs they feel necessary, and work these things through with the planning council, Blue Cross in the state, and so on, ahead of time, unless somebody comes along and says that by fiat or statute or whatnot these have to be cut out of patient care costs and financed in some other way, which is possible.

MR. MAY: One of the problems I see with Harold's plan is that we will have come full circle. I think we would be dealing with the public in about the same attitude as we dealt with them before the advent of service benefits, when indemnity contracts existed and the patient paid his own bill. In a hospital in a single community, or even in multiple hospitals, people paid different amounts. They paid an indemnity, and the patient picked up the difference. What I think will happen is that there is no reason why that cycle will not continue. There will be a public demand again for service benefits and for that additional amount to be covered. Just as insurance companies today pay different charges to different hospitals, they may have to pay different surcharges to different hospitals; and there is no equity in that kind of system.

MR. HINDERER: Remember, under this you would always have 50 percent and maybe more of the facilities available without surcharge.

MR. MAY: What is to prevent the public, who happen to be patients in the other 50 percent of the hospitals, from demanding insurance coverage for that surcharge?

MR. HINDERER: First of all, I don't know whether the insurance industry would consider this an underwriteable risk, because it would be purely selective. Anybody who bought this kind of insurance would be buying it because he wants to go to a hospital that has proven to be higher. So, it is absolutely selective, and I question whether the insurance industry would write it.

The second part: If indeed the insurance industry would write it, then I think it would have to come by statute or by law—that insurance could not be written for less than a \$500 deductible, or something like that, on the surcharges.

MR. MAY: Don't you think the public would demand that kind of coverage?

MR. HINDERER: If the public demanded that kind of coverage, then the whole thing upon which mine is based, which is H.R. 1, would be out the window. If Congress would change on this, fine; then my thing doesn't hold water as a control mechanism.

MR. HILL: What has happened in Philadelphia with Mr. Dennenberg's shopping list? Does anybody know? Have the low-cost hospitals been swamped with business?

MR. OWEN: Since South Jersey was also listed in his group of hospitals, we have not seen anything at all happen. Most of the people couldn't care less, because Blue Cross is paying for it. When we looked at the Pennsylvania hospitals and a couple of the medical schools in Pennsylvania, it seemed they would have had a rush of people going through there because there was twice as much cost there as there was in a little rural hospital in South Jersey. But that didn't occur, either.

REMARK: I still think the main point to be

debated in Harold's argument is this: In the hospital system in this country we want to structure it so that economic decision is made in response to financial incentive. That is a different thing than saying you can make economic decisions in response to financial help. That is to say, you don't spend money if you can help it, unless you get it back from some place else.

It seems to me the basic theory that underlies this whole business of incentives goes all the way back three or four years. I think people need to debate and think about it. We have more or less deliberately created a whole structure of health services, so organized that it need not do that. That is to say, it creates the ability and the incentive to make decisions on the basis of what seems sensible, in the context that you get what you spend for, recognizing that you can't measure what you get.

It is a profound decision to now say we don't want to do that any more—that we want to hold a dollar bill out here, and if you can get the costs down you can have the dollar bill. I am not so sure myself that that is the kind of system I want. That is the point I was raising.

QUESTION: Can I manipulate the demand under your system?

CHAIRMAN MAY: To the extent you are doing it now, of course you can.

REMARK: No. Just look at the statistics in hospitals. The average admissions in Kaiser hospitals are 20 percent obstetrical. That is really because of the benefit system or the benefit structure they put together. They also stay 2.2 days. I feel that in the really highly competitive community you are talking about, it wouldn't take me very long to figure out that I would want all general practitioners 60 years and older, and I wouldn't let any bright young internists on the staff, because they write all the orders.

MR. HINDERER: Let's look at this, Frank: How many of the costs that I have are actually determinable or influenced by the doctor himself? Let's take a laboratory. There is a certain amount of routine lab work that must be done. This we should be able to identify, and I would bid the same as you would bid on routine care, lab work, and what else might be in there. I would even go so far as to say perhaps routine drugs (whatever routine drugs are), of course with certain exceptions.

Now, the doctor himself, if these standards are established, is not going to have very much of an influence on how many conventions I send my people to, or on how much my nursing service cost is. He might insist on more nurses. It may end up by perhaps my having to pay more and having to charge more.

REMARK: My appendectomies stay eight days, and yours stay four. I don't need as many nurses.

MR. HINDERER: All right. What is the average length of stay for an appendectomy? This is what would be spelled out. I would not be hurt if mine stayed eight days, if the average, let's say, is six days. I will get paid for my six days and my bid price, and for the extra two days I would recover only my marginal costs.

REMARK: The assumption in your whole thesis is that we have a highly skilled, well-paid staff somewhere in the governmental structure that is capable of handling this. I just have to dismiss that with a wave of the hand. This is exactly the problem in New Jersey. If the New Jersey hospitals were not paying themselves for the review system, much as we get mad at Jack for it, if we were not paying for it ourselves, I shudder to think of the kinds of people who would be making the kinds of arbitrary decisions you are talking about.

MR. HINDERER: Again we come back to two points. One, H.R. 1 directs the Department of Health, Education and Welfare to establish these standards. Two, is there any reason why the standards could not be established by medicine itself?

QUESTION: With the disincentives for providing the costly specialty services under prospective reimbursement, where does the protection come from for monopolistic exploitation of specialty services on the one hand, and the proprietary bread-and-butter medicine on the other hand? Where does the protection come from? There is little incentive to sustain and develop the costly specialty services under prospective reimbursement.

MR. HILL: Not necessarily. It depends on the kind of system one has. I think what you are getting at is this: If in a prospective reimbursement system (and I think Jack alluded to this earlier), this is where the averaging and the

grouping problem tends to come, or when ceilings or something like that are clamped onto it. If, on the other hand, the prospective kind of development is a one-to-one bargaining situation, then there is no such impediment on specialized services or educational costs, or anything of the sort.

Or, even if you have an area-wide approach to this, and you decide that in some fashion or other within the area these kinds of services have to be offered, and then judgments are made how best they are offered within that kind of area, you still can get to it. So, I don't think prospective, in itself, would impede or inhibit specialized services.

QUESTION: Wouldn't you want to back out first when you start getting in trouble, and back out of your high-cost specialty services?

MR. HILL: If you get in trouble, perhaps.

REMARK: That is the first thing to go.

MR. HINDERER: The way I look at it, your high-cost specialty services would be separate, biddable items. This would be taken again the same as everything else. Let's say the hospital bids on type A operations. Maybe some open heart surgeries. Okay; they will bid on these. But they are also going to be bidding on your routine appendectomy-cholecystectomy type of procedures, the routine type of medical patient too, and if they want to get those costs they will not be influenced by the cost of your open heart surgery because they will not be apportioned to these. The costs for routine care, if I may use the term, will be determined and will be on a bid price of their own.

Somebody has this type A kind of operation, and he bids on this. If somebody else wants to bid on it, and they come in with the same price, it really doesn't make any difference. We say we have duplication of service. If one place bids, let's say, \$100 (whatever that means), and somebody else comes in and says, "I am going to start up this service too, and I will bid \$100 on it," that is what we are going to look at, and how is society hurt if we have two people rendering a high-class service, but each of them rendering it at the same cost, the same bid price, that this other fellow would be rendering it at.

REMARK: In deciding the quality of services to health care, we know that in Philadelphia

Blue Cross if the physician feels the patient should stay in the hospital at his own discretion, and the physician disputes that, Blue Cross disputes that, then the physician has to pay for it. In that case also the courts have decided that it is the right of the mentally retarded patients to have the same quality of health care even if they can't fight for it. The courts have played a very active role in insisting upon the standards and quality of services to be provided.

CHAIRMAN MAY: Let me take a step back at this point, and ask a question that I think is really relevant to all four of the things we heard this morning.

All of the literature that I know of in the field of regulation of any particular industry always comes back to the point that the regulatory body gets taken over by the people who are being regulated, and the whole process becomes vitiated as a result. The conclusion is that you can't really effectively regulate yourself.

We are starting in the health field with that process. All of the schemes we heard about are essentially internally generated, internally coordinated, internally administered. Can you really expect to get effective controls from society's point of view as long as we go this way?

MR. OWEN: My comment on that would be yes, because I really believe that if the government (in our case the State) has the final say on certificate of need, on quality of care, on great determination, that is where the public has its input. They are elected. In a democracy that is the true way to get your final input into the system.

Up to the point where that final decision is made, you might say it is private government, and I see nothing wrong with that. It can be questioned, and people can take a look at it; but I think as long as the final decision is made within the state from an appointed official or elected governor, that is the input. If the public is not happy with that, they should throw the rascals out and get somebody else in.

CHAIRMAN MAY: But the counter evidence is the ECC and ICC, both of which operate the same way, and both of which are ineffective from the point of view of outcome.

MR. HILL: Let me put out a couple of prem-

ises. One would be that I think experience has shown in pragmatic fashion that even when a legislative body, totally divorced from whatever enterprise it is, is forced to regulate or comment on that activity, they are forced almost to turn to those people knowledgeable about that activity to make an intelligent comment. So, I don't know who you would get to regulate a health enterprise other than people who have some knowledge about health. That is one premise.

The other premise is—and I may be drawing an oversimplified analogy here, going back to some of my dimmer days in the past when I used to perform as a musician. We liked to perform primarily for other musicians. I really didn't give a damn what the guy out on the dance floor or at the bar thought I sounded like; as long as the other musicians felt I sounded good, I was happy. I would perform harder and try to do better so that I would be looked upon favorably in the eyes of my colleagues than some third party in whose knowledge I had no confidence.

CHAIRMAN MAY: Those are precisely the arguments the railroads used when they took over the ICC; the same two.

MR. HINDERER: If I am the guy who is out there, Larry, and if I don't like your music, how much are the other musicians going to pay to hear you?

MR. HILL: No question about it, I had to compromise.

QUESTION: I would like to ask Mr. Owen what it is going to take the State of New Jersey to allow you to continue your rate review mechanism after 1974. In 1971 you reduced the requests by 2 percent, and in 1972 by 4 percent. What do you think it is going to take to reduce that to satisfy the government now? You can always come in with higher requests, I am sure, and possibly reduce them by 10 percent if you will.

QUESTION: When is the next election?

MR. OWEN: I really don't think the reduction is necessary as to whether we keep it or not, that is, the amount of the reduction, or 2 or 4 percent. One thing you have to take into consideration is that in addition to that which was cut, the budgets were cut by the hospitals them-

selves before they came in, which had an effect that adds up considerably.

The question we are faced with in the Department of Health is, is the budget review system we are using, the data we are using, accurate? What kinds of formulas? They would like to see a formula, some mathematical formula, rather than a subjective look at the hospitals. That is our problem.

Let's take a hospital that comes in. What happened to the one I put on the board? It happened to be in a densely populated ghetto area. They had a tremendous increase in security costs, for one thing, which they didn't have before. Is that a legitimate expense for a community hospital? It wouldn't come out in the computer, or it wouldn't come out in any kind of formula, but it was a fact of life that if you wanted to go to your car at night and not be mugged you had to have guards and dogs and fences around you. Those are the kinds of things we are having a problem with with the Department of Health, that doesn't want to recognize that kind of subjective approach.

I notice there is a question on the board about it. We have an industrial engineering program we are starting. We are hoping that that will be of some value, and maybe our hospital administrators can comment on it. We have what we call a power package, which is to look at productivity and audit review, in which in six weeks' time we can take a look at all of the departments in the hospital and come up with some idea of their productivity. We are hoping that the hospitals will be able to use that—if their productivity is good, that is. If it is good, it is going to be hard to refute that in a budget review session.

Remember, we have institutions dating from 1898 up to 1971, and there are all phases of maintenance and all the other problems and inefficiencies that go with them. This is why we are so concerned in keeping each hospital. Then, when you have an individual hospital and start looking at its record, you ask why they added fifteen people in the lab from last year. What happened? This is the kind of thing they have to explain when they come in. Our problem is not cutting the hospital costs as much as it is getting credibility from the Department of Health.

QUESTION: In connection with the point about franchising, I am curious as to whether or not you think, Mr. Hill, the prospective rate review



committees will take on the role of public regulatory commissions.

MR. HILL: I think the assumption is yes, and I think this has had legislative approval in a tacit sense rather than in an overt sense. In my judgment it comes back again to what Joel has said. Whenever a group is faced with controlling something as complicated and as emotion-laden as medical care, they frankly get kind of frightened with it. It was interesting that one bill I mentioned, that would have given the Insurance Commissioner the right to set rates unilaterally—at the hearings in front of the legislative committees he was up there testifying against it, in the greatest emotional manner you could imagine. The idea of having to do that terrified me.

Therefore, it seems to me that as people look around, they feel that this kind of process, this business of forcing people to think ahead, to plan ahead, to compete with each other in a sense for a limited amount of resources in the total medical care community, is probably as effective a mechanism as there is now known for the public to use in the way of regulating costs.

I am sure if you walked out on the street and asked the public, they wouldn't know what you were talking about; but if you talked to the legislators on the Hill, this is the kind of response you would tend to get, with the statement that I think Jack is alluding to also: "We will give it a try, and boy! if something doesn't happen then we'll think of something new." I am not sure that is responsive to your question, sir.

QUESTION: I have a question for those doing prospective budgeting. With the footwork being done as of April 18, the announcement that we will have to provide charity, I wonder how you are going to finance this in your prospective budgeting to convince somebody they will have to conclude that.

QUESTION: Somebody will have to pay for it. So, my question is, who pays for it? You have Blue Cross in Rhode Island, Connecticut, New Jersey. Are they going to reimburse for it?

MR. OWEN: No, they don't in New Jersey.

MR. MAY: In Connecticut they do. They already pay for a share of bad debts and free care.

MR. HILL: In Rhode Island, Blue Cross has built into the agreement something called responsibility factor. I have a feeling 5 percent may have hit them squarely between the eyes, too.

CHAIRMAN MAY: I was handed a question that I want to read, and I think it is really a question as much for those of you in the audience as it is for the people on the platform.

"Given the emphasis of government on prepaid practice, how could a private or voluntary hospital adjust its charge structure or its cost reimbursement structure to assume survival as a freestanding medical facility in a group prepaid world?"

That is an interesting question. If we go the HMO route, for example, what does it mean to your scheme, Harold?

MR. HINDERER: This brings us to the ultimate. It brings us to what Paul was saying, where we come to the ultimate product. The ultimate product is total health care for an individual.

I personally do not see where the HMO, fitting in the way I am talking about, would do anything but make it thoroughly complete. I think the hospital aspect of this would have to run efficiently. I see with the capitation type payment there are so many dollars available. The doctors have so many beds available to them. They have so many people in their HMO, and they are limited in the number of people that they can have in their HMO by the availability of beds.

As the doctors learn to shift the emphasis from bed care to outpatient care, it frees up beds for them so that they can then take on more subscribers in their HMO. The hospital is going to have to be paid. It is pretty easy if we say there is capitation. The hospital is part of an HMO. We have no difficulty projecting our costs. I just don't see a problem, Joel. There is no difficulty projecting our costs. If we run it too inefficiently, or if we don't run it efficiently, we are going to have great pressure from our doctors. The doctors are the ones who are going to have to bid to the Secretary or to whomever the great white father is, who is going to do this. We will take care of a total segment of population for this much per year per person.

CHAIRMAN MAY: What about the hospitals?

That is the question. Are you going to book eight admissions per 1,000 people and bid on that? How are you going to bid on a per person basis from a hospital point of view?

MR. HINDERER: We are not. Our dealings would be purely with the doctors, that we will render service to them on this cost.

CHAIRMAN MAY: Jack, you wanted to say a little more about the administrative structure of New Jersey.

MR. OWEN: Yes. So that you completely understand the situation in New Jersey and the cost control or planning bill that we have, which is a very stringent and strict control bill, the final decision making does not rest with the Commissioner of Health. I don't know whether this came out or not, and I don't think I mentioned it this morning.

Under our law we have a Health Care Administration Board. This Board is responsible for the law, which includes all the stuff we have been talking about—certificates of need, the budget, and all the rest. This Board has thirteen members, two of whom will be the Commissioner of Insurance and the Commissioner of Health. The other eleven are appointed by the Governor with the advice and consent of the Senate. Of the eleven members, nine are hospital trustees.

So, bad as our bill may seem, and stringent, it really doesn't make a czar out of the Commissioner of Health. We do have a very knowledgeable Board, and one which the hospitals can work with. I think this is most important. If this bill were in the hands of one individual subject to the whims of politicians and the party, I think we would be in pretty sad shape.

We have one other bill that has been introduced this year, which will add one more thing to our program, and that is a Hospital Bonding Authority. The bill that came in stated that the Bonding Authority would be separate from our Health Care Administration Board. I think yesterday we were successful in amending this bill, which would make our Health Care Administration Board the Bonding Authority as well as the controlling authority.

There is a very important aspect of this, because this bill would make this body a corporate political organization, and in so doing would allow them to hire staff, and would not be subject to the problems of civil service. So,

we might see something happening in our State that would give our Health Care Administration Board a lot more strength but at the same time the ability to hire competent people, which is one of the problems brought out here earlier, that of bureaucracies.

QUESTION: One thing has bothered me about the discussion today, and I suppose it is the same thing that bothers me in discussions about controls in general. It seems that our discussion makes the basic assumption—and the government makes the assumption—that the health care industry is poorly managed, inefficient, and costs too much. It seems that the health industry is accepting this and is beginning to design controls.

I wonder whether the panel thinks these assumptions are valid. If they are not valid, then why do we not spend our time saying so, and trying to influence them to see our position?

MR. OWEN: I will start commenting on that. I don't feel health care is inefficient, or even that the costs are too much; but I think with the public dollars that are going into health care, you just can't get out of the political arena. I think you are foolish to think we can take public dollars and then sit back and say we are going to run like a local gas station. It isn't going to happen. This is what legislators run on—that is, what happens to the consumer dollar.

As far as I am concerned, I don't think it is a question of whether you are efficient or not. You can be the most inefficient hospital and have the lowest cost. I don't think that will keep you out of this public accountability factor that is there when you are using public dollars. It is a fact of life.

MR. HILL: I would add that I think one has to take a kind of historical look at this. I think it is not untrue to say that from the end of World War II perhaps through the 1950s, the hospitals were riding pretty high, wide and handsome. Everybody had building programs going. Hill-Burton funds were flowing. Bigger and better everything was the word. Costs were going up. Blue Cross rates of sales were going sky high. The private insurance industry was selling insurance like mad, and everything was sort of fun and games.

All of a sudden, then, I think many others in the health field (and schools of public health have turned them out for 30 years) were taught

to believe that they were out and hospitals were in, and therefore to many of these people who inhabit most of our public health service, for example, and who get to congressmen, hospitals have become a four-letter word.

I invite anybody to go to either state or federal legislators, and you will find that hospitals are four-letter words along with physicians to a large degree. Therefore we have been landed on now as the great villains in the whole piece of delivery of health care. We have been assigned huge responsibilities and then are told we are spending too much money. Others are coming to Congress and saying we are not living up to our responsibilities, that we are aloof, that we are disinterested. Others are saying the quality of care is terrible. This too will end. Somebody else is going to be a villain pretty soon at some time or other.

In the meantime, I think what we are all groping for is to come back to what Jack said—that somebody will have to demonstrate (and it is probably the legislative group primarily) that after all we are not all that unconcerned, not all that irresponsible, not all that inefficient. And if you don't believe me, here is that kind of mechanism of review and analysis that will demonstrate that. Nobody knows how to design that, really.

REMARK: I worry about where we will go down the long road on this. I am sorry Stan Martin isn't here, because I think some of the Canadian experience would be helpful at this point.

As far as British Columbia is concerned, I watched them in the middle 1950s decide to put rate controls on hospitals by the government. I now see them in a completely governmental operation of all hospitals across all of the provinces. They took it in slow stages. They are doing roughly what we are talking about at the present time. This didn't satisfy government, and government didn't really feel they could control as long as they were responsible for the expenditures. They said, "Let's operate and really control these hospitals." I think we are really taking steps along the road. I can't see it any other way.

This has problems. Let me tell you one story from British Columbia that happened within the last month. They decided in Vancouver and for the province that the most effective way to tackle open heart surgery was to have one hospital do it. We had one hospital that was all set up for this. They developed a long waiting list. One

of the men down on the list, who had a wife who was politically pretty well known—the doctors certified that this man would have to wait his turn on the list for about five months before he could be operated on. He was told he would die within two months. This got into the newspapers. The government paid this man and his wife to go to Montreal, have the surgery done in Montreal, and then paid for her hotel room while they were there. The man recovered. If you don't think the other seventy or eighty people on that waiting list weren't mad, and if you don't think this has created some major problems, you're wrong.

I think this is the way we are moving, and we might as well admit it. I am not sure in my own mind that the steps we are taking at this point are the right ones. That is what is bothering me.

CHAIRMAN MAY: That is bothering me a bit too, in the sense that when you talk about controls you have to know before you start controlling anything what it is you want to control, and why, and how you want the world to be different as a result of the control being imposed. I don't think we know that. That is one of the problems we have been having with the output discussion we have had two or three times during the day.

I think we spent a lot of time today talking about the mechanism for control, and the details of it, and how it is going to work, and we really don't know what the outcome is going to be. If we take Harold's idea and build up a world in which it exists, are the total costs of hospital care going to be lower for the same number of people? Are there going to be fewer people taken care of at the same cost, and thus the total bill be smaller? Will more people be taken care of at a lower cost? I don't think that is at all obvious, nor is it obvious which we want to have happen. There is a prior step which we have sort of walked around instead of barging through.

QUESTION: A corollary to that is that we had more or less freedom in the past to come to our own decisions, and I think Mr. Hill's point was that that freedom has evaporated. Whether we like it or not, we were nationalized on July 1, 1966. Call it any name you want, but as Jim has said, we are going to get there.

I would like to leave that, and I would like

to throw a question at the panel because there may have been some reference this morning that I missed.

Essentially I have heard the comment that we are doing it with the government, and that we are doing it with Blue Cross, and so on. I haven't heard any discussion to amount to anything about getting prospective rating for the commercial insurance industry, for Medicaid and Medicare, and getting all of the third-party payors paying on the basis of prospective rating.

Really, what Harold has said is that everybody has got to do it; but the rest of us have kind of looked at Harold's example and have been sort of traumatized with the idea of making change and adjusting to his pattern, and we haven't looked at bringing the third-party payors into this total prospective mechanism. I would like the panel to comment.

CHAIRMAN MAY: Is there any activity in New Jersey?

MR. OWEN: In New Jersey all governmental is covered except Medicare plus Blue Cross. No commercial. That is one of the things we would like to see happen eventually. There is a suit right now with twenty-two hospitals. The papers were served on Wednesday of this past week. Again, the question we were concerned about was that unless we got the local government to pay, the make-up—because Blue Cross doesn't pay for loss on indigents, nor does Medicare, nor does Medicaid, which is the biggest group—so we have to get a price that is something more than just the accounting costs in this rate established by eventually the Health Care Administration Board.

QUESTION: Do you think you really have a chance to get the commercials in ultimately, and get HEW in finally?

MR. OWEN: I don't know about HEW, but I think the time is coming when we can't have the discrimination we have with the commercials. We have a big discrimination in New Jersey.

MR. HILL: I told you we have only 3 percent commercial coverage, so we are not concerned about it. As I would sense it, the key to getting the commercials in, or self-pay, or whatever, is to stop talking about costs versus charges and talk about a price for care; and if you then negotiate a price with a buyer, what you tend

to do is charge everybody else the same price. I would dearly love to see Medicare, Medicaid, Blue Cross, Red Cross, Green Cross, Travelers, and everybody else, charge a price. Then I think they are in it, willy-nilly.

REMARK: Coming back to Jim's question, if we can't get the commercials in, and if we don't get HEW in, then we have only a temporary situation, and HEW is going to whistle the tune, and we are going to jump to it, or somebody else is going to whistle the tune, however it is set up. We are really in a transitory stage.

REMARK: Are you including in these negotiations some way to get innovative new services introduced, not necessarily six months before somebody thinks about them but three months after they think about them, and these develop? This is a major problem also from my point of view, because I think the way we develop in this country is that we develop by the introduction of new services and new techniques.

We have probably forty lab tests that are being developed at NIH that are not in use in our hospitals at this point, and yet the minute these become standardized we ought to be able to utilize them. That, you can't wait eight months on.

MR. DAVID JOHNSON: I would like to pursue a little bit the subject we have been talking about in this corner, about where we are leading ourselves. I hear Jim talk to that subject, and I hear the various panel members saying this is the program they have evolved in this area. We in Indiana have talked about great reimbursement for a long, long time, and we get hung up on it as we talk with HEW and give up the thought.

I wonder if at some point in time we are going to be making it more difficult for ourselves, even if government would do it to us. We have been so sophisticated in tying our own throat and nailing it to the wall that even we ourselves are having a tough time learning to untie ourselves.

I wonder about the propriety of public judgment, public policy on the one hand, in contrast to at what point we ourselves make the world's finest or worst jails that we are going to eventually live in. I kind of feel badly, like being part of the contractor who is building it. It makes me wonder if the standards are really appropriate as we went about it, and who wrote the specifications, and do I really want to live there when we are done.

CHAIRMAN MAY: I think the question a few minutes ago indicates there is indeed a felt need for some sort of control of what is going on—some sort of rationality. I was working fairly closely with area-wide planners when the principles of financial reimbursement were before us, and I never saw a group run faster than they did from the proposal that they indeed hold the funded depreciation and allocate it. There was a vacuum. Nobody wanted to do it, and we, the industry, are moving in. I don't think we have any choice.

REMARK: I think Jack used the right word when he talked about credibility. I think what we are into is an organizational problem that runs like this: How do you create a decision-making structure that makes somebody accountable for both the economic and the service consequences of the decision? What has happened with third-party payment is that the local institution had one leg but didn't have the other. They were accountable for the service side but not for the financial side.

It seems to me what we are struggling toward is to try to bring the financial side and the service side back into closer proximity to each other so that whoever makes decisions that affect one has to take the rap for the consequences on the other side as well. I think we tend to go to extremes.

As Harley said, for a while it was more, and suddenly it turned out to be less than what everybody wants. Well, either one of those is not totally right, I think. There is still room for novel suggestion and ingenious thinking. Are there other ways to structure this decision-making process other than just sort of a thoughtless trend toward continuing centralization? I guess that takes brain power.

REMARK: We have sat here all afternoon and pulled Harold's thesis apart. We are a bunch of reactionaries. He ought to have a chance to experiment with it and do it. We talked over here about obstetrics in 2.4 days. I can remember when obstetrics was ten days, and anybody who discharged a patient within ten days had holes in his head. It was innovative or something. We will have innovation because there are souls in this world who won't do without it.

REMARK: One essential thing that is missing from this panel, I think, is the input from the medical group and the medical society. I think

we are talking about total health care, and we have a certain package and they have a package, and if you don't put those two packages together you are not going to get what I think the people in the United States want.

REMARK: Joel, I think it is clearer than you implied where the controls are directed. I don't think they are just necessarily directed to the efficiency that may be caused in the individual hospital. They are directed toward trying to rationalize the system and the control of resources. Getting rid of the duplication. Let's not have such-and-such beds.

CHAIRMAN MAY: I think that is reasonable. We have had a very interesting afternoon and a full one, and I thank you all for your participation. I can't adjourn the meeting for the afternoon without mentioning one thing.

In the context of considering the effect of prospective budgeting on individual hospital operation, there are questions I thought I would want to ask if I were a hospital administrator and somebody was whispering "prospective budgeting" around the corner of my institution. This is a checklist that I would use as an administrator to deal with the establishment or development of a prospective budgeting scheme in the state.

1. Geographic area served.
2. Number and type of hospitals involved.
3. Stated purpose of the program.
4. Administrative agency responsible.
5. Review of advisory committee:
  - a) Who?
  - b) How appointed?
  - c) Authority?
6. Annual budget of administrative agency.
  - a) Source of funds.
7. Detail of procedures used:
  - a) Forms.
  - b) Time frames.
  - c) How are allowable increases calculated?
  - d) How are hospitals grouped?
  - e) What expenses are included?
  - f) Procedures for approving new construction.
  - g) Procedures for services and/or programs.
  - h) Appeals.
8. Current sophistication of hospital in cost accounting.
9. Accuracy and value of comparative costs.
10. Role (if any) of management engineering.
11. Are hospitals assisted by field personnel?

CHAIRMAN MAY: This is not a complete list by any means, but it seems to me useful. The meeting stands adjourned until dinner.

## Who Shall Judge the Feast

MARTIN DREBIN

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CHAIRMAN MAY: I want to take a minute to introduce to you somebody you already know, who in terms of this relationships to me, to the University and to the program has changed a great deal in the last few weeks. Odin Anderson, who was our Director of Research and who used to be a colleague of mine, as of April 1 was appointed Director of the Center for Health Administration Studies, and as a result he becomes my boss.

Those of us in the Center when Bob Daniels left had quite a lot of worry about what was going to happen. Faculty, budget and all the rest are very important. The Search Committee, which the Dean of the Business School chaired, and which consisted of a group of informed and thoughtful people on the campus, looked hard, long and wide, and, I guess in a way that many hospitals do when they have engaged an executive search firm and then end up promoting an associate, they found indeed the grass is greener in their own back yard than any place else. We are very pleased to have Odin as our Director.

The speaker tonight is Martin Drebin. I referred to him earlier today as being good and short, I think he will be short and good.

I have heard Martin speak a couple of times at various meetings, and I have found him entertaining and informative.

Just to add a little tone to the evening, when we talked about a title for this evening's presentation Martin suggested a quote from Aristotle, and I am anxious to see just how this group copes with Aristotle. Martin Drebin, "Who Shall Judge the Feast."

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MR. MARTIN DREBIN: I really wasn't kidding Joel this afternoon. I really am sort of tired of hearing what I was going to say. It was sort of interesting and I didn't find anything to disagree with strongly. We have some obligation to occupy some short amount of time; but, rather than make any kind of formal presentation, I would like to continue some of the discussion

we had this afternoon because I think it is terribly important. As a matter of fact, I am perfectly willing and anxious to make this a discussion. Please don't hesitate to speak out whenever you feel that something is worth further discussion. Don't bother raising your hands to be recognized; just speak right up. I have a microphone, which I guess gives me certain powers that you don't possess; but don't hesitate to try to shout me. If you don't, I will be hypnotized by my own voice and not even notice you raising your hands.

The Aristotle quote is one which I find very applicable to what I consider to be the biggest problem of all. Its size is evident by the fact that you spent most of the day talking about it. Aristotle asked basically, "Will the guest judge better of the feast than the cook?" This was after a long series of examples which included: "Is the pilot a better judge of the rudder than the carpenter?" Or, "Is the owner a better judge of the house than the builder?" Pick any one you want, the message is always the same.

I find fantastic pressures in the health care experiments, legislation and discussions of today for all kinds of people to get deeply involved in deciding what the health care system will be, because they consider themselves very good guests at the meal, and hence well equipped to decide what constitutes a good meal, a good rudder, a good house, or a good whatever Aristotle in his homely way might have brought up. We have to recognize, however, that Aristotle restricted his questions to certain arts whose products are recognized by everybody, without the need for any special training.

I am really an outsider, and my orientation in health care is more that of a consumer. I visit hospitals most often on my regular trips to the local hospital with one or the other of the participants in the Drebin Prepaid Health Plan (prepaid by my salary check) which guarantees payment if the hospital ever gets around to billing me. It has been 4 weeks since

I made my last trip to the hospital; an uninsured quick visit to the emergency room for an x-ray of a small hand. The \$20 emergency room charge and the \$6.95 for the x-ray have yet to be billed. I notice that the radiologist that billed me has been paid already. He of course wasn't within 200 miles of the hospital.

We are used to the routine by now. The resident says, "Off you go", and the kids know the way to x-ray. They come back, the resident looks at the picture and says, "Put a cast or splint on it and get out of here." Somehow the radiologist finds it quite possible to bill me the following Thursday for his \$5. The hospital finds it impossible to bill me for the \$26.95 I owe them. I am unwilling to call anybody. My curiosity says, "How long will it take?"

It seems to me that a word that was used this afternoon—credibility—ties in here. While I now find this billing situation somewhat ludicrous and hilarious, credibility ties in here also. The hospital industry has really, through its own negligence, lost all credibility with the public. It seems to me that the reason the public thinks that somebody else had better run the hospital is because they are firmly convinced that today you can't do it.

Pick up any periodical at random. Go out to the newsstand, pick up a magazine or newspaper, and what do you find? An attack on the hospitals. *Saturday Review* has done so; the *Wall Street Journal* has done so; *Fortune*, *Time* and *Newsweek* published an amazing chart of the Consumer Price Index versus the hospital routine service charge. Nowhere do I see an article saying, "The hell it is! The devil you say! We aren't that bad." All I can ever find are articles saying the hospitals don't know what they are doing—that hospital managements are inefficient. What other great words do they use? You know the point I am trying to make. Even *Better Homes and Gardens* attacked you in 1970. Do you realize what a crisis you have? The little housewife looking for a way to put tulip bulbs in right side up, or upside down, suddenly sees an article saying that health care is going to hell. I truly blame the industry for it.

All afternoon you stood up and said, "We are not so bad." You all agreed, and you now will go home happy because you have convinced each other, and you will write articles in all the trade publications. It is hard to pick up *Modern Hospital* or the *AHA Journal* without finding

articles telling yourselves how good you are. But I don't believe the public perceives this at all. I think the public takes the view that if you are being attacked so regularly, and you never at any point tell them it ain't true, that that isn't the way it is, that things aren't that bad, "and here are the facts," then one of two things exists: Either you are very, very dumb (which is one of the accusations), or it is true.

Put yourself in the position of one of your consumers who reads the articles all the time, gets a bill probably 60 days late, and wrong, like I do. As sort of a casual consumer, what answer can I come to? The answer has to be that all the accusations that I see in the press are true. You are wasting my money; you are giving me excessive medical care; you don't know what you are doing. What, then, is the response of any average, plain man at any time when he feels somebody is taking advantage of him? Most often it is "Let's pass a law." That is the American way. So, there are all kinds of pressures in many places to pass a law regulating hospitals.

I think the time has now passed, unfortunately, to ever stop this pressure. In other words, I don't think we can any longer talk the way we talked in 1966 or 1967 about let's do something quick before they pass a law, because I for one am willing to admit that they are going to pass a law, come hell or high water.

I think you might have some influence on what kind of law is passed. If you regain any credibility with the public you might be able to get raped in your own bed rather than in a back alley, but it is going to happen either way. The question is whether you want it at least a bit comfortably.

At this point I have great faith that something is going to happen. But I am awed at the fact that the hospital industry is spending all of its time reacting to pressures, but not taking the initiative. Just think about what you heard today. Every one of these great experiments took place in response to a threat that the state was going to do something more serious. Everybody said, "We suddenly recognized that the legislature was going to write a law, so we thought we had better do something first to head them off." This is not the kind of stuff the industry survival is made of. For contrast . . . look at the most abominable of all industries, the American railroads. This is an industry probably beyond hope.

Have you read their ads? Have you seen their stuff? "Railroads are great. Railroads are important. All the government has to do is loan us \$100 million for new equipment. Write your congressman!"

So I am aware that nobody tells me that hospitals aren't that bad. I don't think you are that bad. Inefficient, yes, sure. Is general Motors inefficient? You bet! Is any business inefficient? Certainly it is if you compare it with theoretical perfection.

The Harvard Feldstein, Martin or Paul, in his recent book on the rising cost of health care, has a great point on inefficiency. A point which is under your nose but never seen. (It was one of the English poets who pointed out some place that everything is very clear once it is beneath your nose. The important thing is to know which way to point that organ.) Martin Feldstein said, "Yes, hospitals are probably inefficient; but you can't blame the rise in the cost of health care on inefficiency, because hospitals are no *more* inefficient than they were ten years ago." I was impressed by it. I don't know whether you are. I think it is good, really obvious.

I happen to think that most of the other charges leveled against the hospitals are at least not completely valid. I think there are objections—which could be raised to these charges—that to my simplistic, health care consumer, mind make a lot of sense. If they don't make sense, tell me as we go through some of them, but don't tell me too loudly, because I sort of like to believe that they do make sense and that therefore you aren't so bad.

I read constantly that there is a horrible problem with duplication of facilities. Omaha has 127 heart pumps, and there are sixteen hyperbaric chambers in Gary, Indiana, and all kinds of wild figures like that. I am told that this duplication of facilities is an important factor in the high cost of health care. I know however that the total capital costs of the typical hospital are about 6 percent of all the costs; isn't that right? Think over your own financial statements. What is your depreciation as a percentage of total cost—6 or 7 percent? Ten percent if you accelerate, maybe? What this says to me is that if you operate in a cornfield with no bricks and mortar at all, you can reduce your costs by a 6 percent maximum. How much of the cost can possibly be due to there being too many hyperbaric chambers and heart pumps?

Now, if you are staffing this blasted hyperbaric chamber 40 hours a week, and using it

once every three months, then you *are* inefficient. But it strikes me that the duplication of facilities argument—and I am not talking on the medical side, as I am aware of the fact that the team that works constantly does a better medical job—but on the financial side) doesn't make any sense because it seems to me that the cost isn't in the facility but in the labor assigned to it. If you are willing to staff this only as you use it, and utilize that staff efficiently the rest of the time, you are doing your job.

I was recently in a hospital which has one of the few Siamese twin separation teams that I have bumped into. Is it important? Yes, because every once in a while somebody sends in a set of twins from Bolivia or somewhere, and the team serves a real purpose. I would hate to think however that this hospital is staffing their Siamese twin separation team 40 hours a week, 52 weeks a year, waiting for somebody to ship them a case.

It is truly a question of whether you are using your people properly. That is where your costs really are. I am not aware of anybody very often raising many complaints with the hospital industry regarding the inefficient use of personnel. There are some, obviously, and personnel can be tightened up a little bit. But I am also not aware of the hospital industry responding that every time we get rid of personnel we may have to lower the care—which, by the way, is probably the way you ought to present it.

Do you know what it means to reduce your budget? When you put the whole budget together, and go to the board, and the board says, "Hell, we can't charge that; cut the budget by 10 percent," can you say to your board, "Wait a second, guys; we can reduce the budget by 10 percent, but here is what it means to do it: no more rooming-in in maternity, for example." (That is something that obviously takes extra staff.) "Are you as a board willing to go on the line in reducing the care in this way?"

In my simplistic bookkeeping mind I have to equate levels of care with dollars. It strikes me that the only thing the dollars represent are levels of care converted into some common denominator that we call a dollar.

In a similar and sort of tangential point, I am frightened by the constant references today to prospective rate review. If you think about it, what is your rate? Nothing but your budget divided by the expected occasions of service. As the budget is nothing but your level of care expressed in dollars, what is the rate review



board truly reviewing? What have you given over to the rate review board if you give them the absolute right of veto over your rates? Haven't you truly given them the absolute right of veto over your levels of care?

All I can ask is: Are you willing to do that? If you are, fine. If you are really willing to turn over to some independent body the decision as to what levels of care should be rendered by your hospital, go ahead and do it. You might have trouble shaving in the morning without slashing your throat if you stay in the business after that, because who needs you, who needs your board of directors, if this will really be determined by some independent body? I always thought that the level of care was the function of management or of the board. I could be wrong, but I am unwilling as a consumer to have this handed over to a relatively untested bunch, because as I said too many times already this evening, I am not convinced that the hospital industry has done that poorly. I am convinced that the effect of politicalization of almost any industry is an instantaneous improvement in the average level of output with little, if any, improvement thereafter.

I assume that postal service was better when the government took it over and threw everybody else out of business—probably better than the service provided by various and sundry individual companies. I assume that in any other area where the government has gone, they have instantaneously improved the average level. I have been told (because I am really not that old) that when the ICC was put together in 1913 it was really forward-looking and greeted with all kinds of applause as being the most magnificent, up-to-date solution. In particular, the accounting system of the ICC in 1913 was greeted with all kinds of huzzahs for its originality, aptness of thought, and so on. I am aware that in 1972 it hasn't changed much, and that since 1913 little things like the arrival of the air lines and the cross-country buses have gotten in the way; and that perhaps there is at least an idea that the ICC system isn't quite as good as it once was. But I think this is what happens when you governmentalize something. That is the thing I really tried to ask Harold this afternoon.

I have a deepseated feeling that much progress comes from inefficiency. Again, tell me if I am wrong. Think what the existence of the redundant hyperbaric chamber really means. Some day somebody is going to drag some guy

into the chamber on the grounds that he is going to die anyway, so let's see what happens. He recovers and walks out of the chamber, taking a candystriper with him.

I feel that at some point this new procedure may then be used to save my life. I am tickled pink that the redundant chamber was there to be used. All progress in health care has not been due to the fantastically detailed, careful study of "This is the way it must work." I get a feeling that a lot of us have a certain amount of inefficiency but I am willing to pay for some of that.

I want my hospital to stay pretty well the way it is. I don't want my hospital governmentalized or handled by some kind of regional planning authority.

You have all heard that the United States stands 14th in the world in infant mortality. As I remember the number, where we are sitting right now there is an infant mortality figure of something like 50 per 1,000 live births; is that about right? Right here, in Woodlawn in Chicago?

VOICE: 49.5.

MR. DREBIN: That's one of the troubles with bookkeepers and accountants. I suppose that puts Woodlawn somewhere below Zambia or Kenya; I don't know where, but not 14th in the world. Probably 140th if they are tracking as many as 140.

I am also aware that the hospital that I go to is running about 5, which I will really stack up against anybody. I am unwilling to give up this system. I don't want anybody to say, "Well, the Chicago average is 20, and Woodlawn is running 50, therefore the obvious answer is to put all the money into Woodlawn." Heck, you would have to do that. If you were responsible for the entire northern end of Illinois, and had all the health care funds in Illinois, could you in good conscience spend 50 cents outside of Woodlawn where you are facing 50 deaths per 1,000 live births?

You see what would happen. Suddenly my hospital goes from five to 20, and Woodlawn goes from 50 to 20, and everybody sits back and says, "Isn't that amazing! Isn't that wonderful! We have actually improved." But not me, because now it is my ox that is getting gored.

Before I forget, of no importance at all, except

as an indication of the governmental mentality look at tonight's newspaper. The government in my local area of Evanston had planned to go wet Saturday night, with all kinds of great joy and excitement. It planned to issue liquor licenses in spite of the WCTU being headquartered there. The Illinois Liquor Control Commission (equated with the Illinois Health Control Commission, if you will) stepped into the thing, and listen to this magnificent quote. "The Illinois Liquor Control Commission decided they couldn't issue licenses in time for Saturday's opening." The Secretary of the Commission said: "The whole thing is being taken under advisement. There are questions here that have to be resolved." When asked what questions had to be resolved, he replied, "That's the question."

Apparently something is bothering him, but he is not quite sure. He has refused to go any farther until he finds out.

Truly, though, I am not at all impressed with the ability of the health care industry to tell the story. I think you do have a story to tell. I think you are being maligned, for the most part unfairly. I know costs are high, but I don't think they are really that high. What are the two items on the chart you always see? The Consumer Price Index is one. What is the other one? Hospital Routine Service Charges. I suggest—and I am not at all attempting to explain all of the difference by any of this—but I suggest there is a certain dishonesty by the way these things are plotted. In the last twelve months both *Time* and *Newsweek* had the same chart in the same week, each of them plotting hospital routine service charges and the CPI.

You can ask a couple of questions about it. The first one I ask is: Why the devil do hospital charges have anything to do with the Consumer Price Index? As any of you know who pay auditors' bills, if you plot your charges against our charges we don't look so good, as our hospital clients point out on occasion. Almost all labor intensive service industries face the same problem. What is the Consumer Price Index? As I remember it, it is the things that a \$7,000 mama with two kids buys, which includes a lot of things which you don't buy, and excludes a lot of things which you do buy. I am just not convinced that they fit on the same chart, or that anybody can draw any conclusions from the differences.

I suggest only in passing, but worth mentioning, the fact that if somebody would have plotted

ancillary charges rather than routines, it would have looked a lot better because the ancillary index stands around 125 right now, and routine at 265 or something like that. Take a look at the medical care component of the Consumer Price Index. I think they plot a routine chest, or something like that. The ancillary charge hasn't changed as much as the routine. Why is that? As you get costs in line with charges, isn't that what you would expect? You remember how some of you used to charge \$20 a day for routine service, and load all of the excess in the ancillary. I am of the opinion it comes from the days when health care policies paid \$20 a day for routine service, and full charges for ancillary. Any rate setter worth his salt recognized that he could put the insurance company on the line for all of the bill by charging \$20 a day for routine and all the rest for ancillary.

It generated a fantastic difference in cost versus charges. I observe that most hospitals, as costs have gone up, have been socking it all under routine service, attempting to match costs and charges by increasing the routine service (which they know is low) and leaving the ancillaries alone. That alone would cause some of this difference, wouldn't it.

If nothing else had changed from 1966 onward, except that you began getting costs and charges in line, what would happen to your routine service charge? Up. But not with the slope that has been observed. Don't go out and try to explain the whole thing away by saying all you have done has been to get costs in line with charges.

What is the rest of the increase? Where is the rest of the cost, other than the obvious wage increases which you keep telling Representative Mills about and he keeps laughing at? Where is the rest of that Index increase? A lot of it is Medicare-induced, isn't it. How much do you have to raise your rates to cover the items that Medicine doesn't pay for? Because you don't get your rates from all your patients? Remember, they are plotting charges, not costs. Given the third-party contracts you have, you raise your rates \$2 and realize \$1 or maybe \$3 and realize \$1. Right? If you are two-thirds Blue Cross-Medicare-Medicaid, which you could well be, you may be in a situation of raising your rates by \$3 and getting \$1. How many of your boards understand that?

The heck with your public for a moment. How many of you really feel that your board of directors understands the financial facts of your hos-

pital, and really understands what it means to be working under a third-party reimbursement scheme? What it means to have to raise your rates by \$2 or \$3 to recognize \$1? I don't think they do, at least not most of them. If your board doesn't, and they have some reason to, I am not convinced your public does, either.

I am back again to the same point, that the public doesn't believe you. Your public has yelled, "Let's pass a law." Politicians being what they are, they will pass such a law because they count noses, and those noses are getting angrier and angrier all the time. You run what to me is a fantastic risk of giving the whole decision process over to people who, as far as I can tell, have, no established record, in determining health care needs in the long run.

Keep in mind that almost anything is good in the short run. What is the effect of Phase 2? To reduce the rate of increase to a maximum 6 percent, as far as I can see. I don't know how long you can do that. I am aware that politically it is very nice—what was Dennenberg's number in Pennsylvania—12 percent? Something like that.

Pennsylvania passes a rule saying nobody can raise their rates by more than 12 percent. Phase 2 passes a rule saying nobody can raise their charges by more than 6 percent. They look back and say, "Look at how good we are! We reduced costs!" You could have reduced your rates 50 percent last year and most of you could have stayed open; right? You might give pretty lousy care, and serve gruel and a vitamin pill instead of a meal, but you would stay open. You wouldn't be able to deliver any high standards. I assume that the cost of health care plus the cost of the funeral may make a little higher total cost, but you would stay open.

Obviously, over the long-run, this is totally unacceptable to those of you who know what it means to have a hospital in a long-term period. Over some period you must recover all of your financial requirements. But remember, politicians don't have to look at it that way.

I have long held the view that the United States could never have a 5-year plan unless it was only the senators who were responsible for it, and then it could run as long as 6 years, because the longest time any administration will plan is a sort of declining 4-year period.

Politicians can't take the long-range view on this thing. In the short run any experiment can look pretty good. I have no doubt that we could run the hospitals of the United States at half

of today's rates for some very short period and make somebody look very, very good. I am also convinced that at the end of the period the entire system would collapse.

I see very little long-range thinking in the plans. I see a lot of people cutting this year's budget and saying, "We can do without it," but I am not aware of any reimbursement proposal that includes what I consider your full capital needs. I think you are running into serious trouble in the long run here. You are not recovering your capital costs, including those of the AHA statement. For the most part, you go in with the AHA statement and you come out of negotiations a little poorer than you went in. Nobody comes out of negotiations stronger. The UAW doesn't think that way. They start asking for \$10,000 an hour and General Motors offers a buck. Somewhere in between they find truth.

But this is a terribly nice industry. You guys keep walking into negotiations saying, "This is justice; this is truth," you begin that way, with truth and justice, and "We will do good; we will be fair," and you find that every time you bump into some kind of alley fighter who assumes you have come in with negotiable fat, because that is the way his game is played.

You get into negotiations with the government, that doesn't know you very well, and assumes that you operate the same way as their experience indicates. They know, for example, that highways do get built better if they give highway builders an incentive to finish faster.

As you discussed this afternoon, incentives to a hospital are a little absurd, because you must keep asking the question, "What am I going to do with them?" The only possible use for the incentive is to make up for the years in which you lost. That strikes me as sort of a silly plan to go into. You can't use the incentive for anything else, given area-wide planning and other restrictions. The government doesn't really understand, as far as I can tell, the basic economics of the hospital. Otherwise, how could Herbert Dennenberg make the statement, "In case of misutilization the hospital shall stand the loss"? How does a hospital stand a loss? What do you do? You raise the charges to me, the private pay patient. If you can't do that, you must reduce services.

Hospitals are not the same as General Motors in this regard. You can't stand a loss. You must pass it on to someone. Anybody who claims that

he can do otherwise is just kidding himself, he doesn't understand the basics of the industry. I thought for a moment Denenberg did. In his first list of points (he had various numbers of points for discussion that he nailed to the Blue Cross door.) He said, "In case of misutilization the hospital won't get paid and neither will the doctor. Blue Shield will refuse to pay the doctor." I noticed when the final version came out that last bit was missing.

I don't attribute this to chance or to some forgetfulness on the part of Mr. Denenberg. More likely the doctors did a better job of negotiating than the hospitals did. Wasn't their case weaker, if anything? If you must penalize somebody for putting a patient in the hospital when he shouldn't be there you should begin by penalizing the doctor and not the hospital. I thought the hospitals would scream and say, "Not us! We don't let them in. We don't control our own destinies"—which, by the way, is worth pointing out more often than you do.

How much of your destiny do you control? This is the only industry I know where the boss doesn't control his sales. That's a funny way to have to operate. I would have thought at some point the hospital administrators would say, "Not me. Go pick on him." I don't see the industry doing it.

All I am really saying is that if you don't start

doing something quickly you are going to be regulated, whether you like it or not, and you will be regulated by people who basically don't know much about the industry or at least haven't shown that they know a lot about the industry. About all you can hope for now is to get back some of the public credibility so that the public is on your side, so that when laws are passed (as eventually they will be) at least they will be more comfortable than they well might be.

I don't know how you will go about it. There are a lot of obvious things. How many of you have had your congressman in the hospital, not as a patient? You have a local congressman. Have you ever walked him through the place and showed him what a tough, rotten business it is, what the facts of life are? Obviously some action is needed on the association front, but that is a different ball game. Unless you begin getting back some of the credibility, the public will believe as it now believes—that you don't know what you are doing, that you are not capable or entitled to manage the health care funds, and I know doggoned well then who is going to be judging the feast. What really scares me is who is going to be picking the bones. I don't like it.

CHAIRMAN MAY: Thank you very much, Marty.

## Health Care Facility Franchising

GEORGE B. ALLEN

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CHAIRMAN MAY: I hope the discussion today will take a slightly different track from what we were on yesterday. Yesterday we were talking about what I would have called, earlier in the session, sort of static constraints on the supply side. We were talking about the sort of controls that are exercised and that take the existing array of facilities and services as given.

Given what we are doing, how can we do it for less cost in different ways for different packages of money? Today I think the sorts of controls we are talking about are dynamic controls on supply. We are not going to hold the number of facilities or range of facilities as given. Instead, we are going to talk about situations in which proposals are made to expand or change or relocate or reorganize services and facilities and programs, and what sorts of controls are likely to be or are being exercised on these sort of dynamic changes.

George Allen, who is the Executive Vice President of the Hospital Association of New York State, has lived with what I call franchising and what he calls something else, for some time. He also has had a chance to look over a report that was prepared for the federal government on franchising laws in a number of states, by an accounting firm, and what we have asked him to do this morning is to talk a little bit about what it means to be in it, and what it means to look at it from an informed viewpoint. George Allen.

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MR. GEORGE ALLEN: Thank you, Joel. I got in a bit late last night, and I could have come down and joined you with your speaker, but I went over to the registration table and looked at the registrants and was stunned and a little scared when I saw Anne Somers' name. I had to go back upstairs and take my paper and take out a lot of quotation marks that I had in it. I have a paper that is half research and half plagiarized from Anne Somers.

The theme of this Symposium—External Controls—is one we hear with increasing and prob-

ably unpleasant frequency. As hospitals become more important to the public, both for their services and their costs, we cannot expect otherwise. The questions to be explored, then, are not whether there will be controls but rather what form they shall take and by whom they will be administered.

That the health field recognizes many of these controls is evidenced by a series of new terms which have appeared in the vocabulary of health professionals over the past few years. Included in this series are such phrases as "labor union," "consumer," "disclosure," "certification," "hospital chains," and the highly complicated "hospital public utility." It is encouraging that these phrases are being used extensively by today's enlightened hospital administrator and are being thoroughly discussed. External controls encompassing labor unions, third party payers, consumers, and government are here to stay, and health facilities are learning to strike a détente with them. The topic of this Symposium is thus very appropriate and timely. My assignment today is to focus on one major type of external control—that of franchising.

In researching existing literature in preparation for this session, it became obvious that the term "franchising" has several meanings and is often used interchangeably with "certification" and "licensing." For purposes of this paper, the definition of franchising is the control of health care facility construction and services by a public authority. If you are a purist, you will recognize that this definition more closely applies to certification, for franchising implies a monopoly in which an institution serves a defined area with specific services for which it receives defined financial advantages [1]. It is generally accepted that competition exists in the health care field since several facilities may draw patients from the same community. In deference to purism, I shall exercise the prerogatives allowed me by Joel May to range freely and use the term "certification" rather than "franchise" for the balance of my presentation.

Having thus dispensed with the matter of

definition, I shall now turn to the approach this paper will follow. Anne Somers, in her fine study, *Hospital Regulation: The Dilemma of Public Policy*, suggests one which would be quite relevant. Mrs. Somers examines regulation in terms of two extremes and then reviews the entire complex middle ground. One extreme she cites as "the spur: profits"; the other "the curb: public utility regulation [2]."

This paper will parallel that format. It will (1) analyze the use of profits by proprietary institutions to control construction and services and conclude it not to be feasible; (2) review the concept of the public utility approach for the same purpose and find it promising but no panacea; and (3) explore the middle ground of certification and pronounce it generally effective. Throughout this approach, I shall be drawing extensively on our experiences in New York State with all three of these.

### *Profits*

Over the last several years, there has been a striking expansion of proprietary ownership of health care facilities, notably nursing homes. Several of these are operating as chains including the well-known Four Seasons (since bankrupt), Geri Care Nursing Centers, and United Convalescent Hospitals. Additionally, private enterprise has become increasingly involved in other health areas in the search for profits; commercial laboratories, multiphasic screening facilities, and contract food services are the better known.

This phenomenal growth of proprietary endeavors in the health care field indicates at the least that we are now recognized as big business and, at the most, that there is a profit to be turned. However, the existence of such enterprises must also be analyzed in terms of the public good; one aspect of which is the provision of adequate and appropriate care. In short, can the profit motive, of itself, control unnecessary construction and duplication of services while still allowing for the provision of good patient care? The answer, from this point of view, is that it cannot. This conclusion is based on several observations.

The first is based on the unavoidable fact that proprietary institutions must turn a profit. To do so, they must avoid those services which are not profitable. Thus, it is highly unusual to find a proprietary hospital providing obstetrical care with its widely fluctuating and usually

low census of the more exotic services as renal dialysis and open heart surgery, both of which are attended by high costs.

Perhaps most telling is the widespread absence of outpatient services in proprietary facilities. While the voluntary hospital has moved to develop such services, the proprietary hospital has not because such services are not profitable.

Next, the profit seeking facility must of necessity avoid patients with fiscal problems. Such patients include those with inadequate third party coverage, those who are chronically ill, and the medically indigent. The tendency is to cater to the affluent or to take advantage of generous reimbursement when it exists.

These tendencies to avoid costly services and costly patients can have a devastating effect in communities where voluntary facilities co-exist with the proprietaries. The former are forced into providing the needed services and caring for the indigent without the benefit of having some paying patients who, of course, are influenced to patronize the proprietary facility. This can seriously disrupt the balance of care in any community.

A further indictment of the profit-making institution which can be voiced is that of inadequate participation of the community. This is particularly true with regard to the "chains" which are remotely controlled by corporations which are possibly conglomerates or merely in the health field because of profit opportunities. Decisions are most apt to be made by management not at all conversant with the health requirements of the community. Such decisions then will always favor the corporation and not the community; the result is a facility which cannot be responsive to local needs.

In regard to chain operations, it is very difficult to establish management responsibility. More often than not, several corporations are interlocked, and they are usually located outside of the states in which these chains operate. In New York, the certificate of need process requires that responsibility be definitely set. Accordingly, chains are not legal. This is accomplished by mandating that stock corporations cannot operate health care facilities in the State.

It is hardly necessary to continue to list further examples. Those who know the health industry recognize that the profit-making approach is not feasible as a control on construction and services. If anything, the system would probably

end up with less facilities than it needed, not more, as is the prevailing concern of today's health planner. Further, most would all be located in the wrong places.

In concluding my discussion on this aspect of control, I do not wish to leave the impression that profit-making enterprises have no role in the health industry. On the contrary, there are commendable examples of such facilities making a fine contribution to health care and, indeed, doing a better job at it than some voluntary institutions. My analysis was directed to the profit motive as a method of control and the conclusion reached that, of itself, it is not feasible.

### *Public Utility*

The second segment of this paper is supposed to review the effectiveness of a public utility as a control on health facility construction. That effectiveness can be summarized in a single word: total. If the health industry were under public regulation, external control would be complete in almost all respects and only total government takeover could be considered more extreme.

Why then is it necessary to devote further consideration to this subject if the conclusion is obvious? It is because a growing number of legislators, business executives, and some spokesmen in the health care field are viewing the public utility as a panacea for the problems besetting the industry. Further, it must be recognized that a number of significant controls are inexorably tied together with that of certification of need, and it is these of which we should be aware. The American Hospital Association lists several [3]:

- Operating standards and practices
- Approval of changes in rates
- Establishment of a uniform set of accounts
- Public accountability
- Establishment of minimum and maximum charges
- Permission for the issuance of capital securities
- Granting of territorial functional exclusivity

As I consider this list in terms of the controls we have in New York State, I can identify only one which is not now in some form controlled by state government. It is the power to grant a territorial franchise. It would thus appear that

in terms of this list, health care facilities in New York are regulated as public utilities. This appearance is deceiving for, regrettably, the State has the controls, but the hospitals do not have the advantages of existing public utilities. Richard Epstein, legal counsel to our Association, cites three of note [4]. One is due process, including the opportunity to be heard whenever a decision is made by a government agency as well as the right to cross examine and to hold a public hearing. Next is the right to appeal to and be heard by a higher authority and lastly, the right of eminent domain; that is, the power to acquire needed real property without having to haggle in the open market.

Dr. Sommers points out some shortcomings of the public utility approach which she dismissed in 1969 as "inappropriate." She stated:

"While the hospital industry shares some characteristics with industries that have been declared public utilities, including some elements of monopoly, there are so many important differences, including the non-profit nature of 85 per cent of the units, the operating deficits incurred by some of the best, the highly individualized nature of the product, and the unique role of the medical staff in influencing hospital policy, that any effort to reason by analogy and to apply the 'public utility model' is inappropriate [5]."

However, experts differ. A. J. G. Priest, a former chairman of the Section on Public Utility Law of the American Bar Association reflects that:

"The analogy between health care and public utility service is not exact, and many hospital executives may feel that they should not adopt the utility concept; . . . Perhaps the public utility is less than apt, but the only alternative (to control of soaring hospital costs) seems to be government ownership and operation [6]."

From our point of view in New York, we are convinced that the hospital industry is over regulated by government and a public utility approach, albeit modified, may indeed be an appropriate alternative. We are actively investigating the possibility.

The AHA's Public Utility Regulation Panel may be right when it concludes:

"It is apparent that analogous regulation of health care institutions would be available that would include avoidance of excessive physical

plant and facilities, establishment of reasonable rates in relation to cost, prevention of rate discrimination, encouragement of efficiency and general promotion of the provision of adequate health care facilities where needed [7].”

### *The Middle Ground*

The main portion of my presentation is devoted to a review of the middle ground of the certification of need process. The term “middle ground” implies a situation in which voluntarism and profiteering may exist but under a set of controls administered by government. In this review, I thought it might be of value to develop it through an analysis of the new guidelines on certification of need just released by the American Hospital Association [8] together with our experiences in New York State.

These guidelines were adopted by the AHA at its February 1972 meeting, but not without some turmoil. They had initially been considered by that organization’s House of Delegates in 1970 but were rejected as too punitive. Now, however, those states still developing certification of need programs can draw upon this document for guidance. It is to the credit of the AHA that it took the initiative in this matter; certainly if we are to live with external controls, we might as well play an active role in their definition.

As a preamble, I think it necessary to cite some of the successes of New York’s experiences in controlled planning. Since our planning law, referred to as Article 28, became effective February 1, 1966, there are more than six years of experience to draw upon. While fourteen other states in the country have officially enacted similar laws, they are very recent, and thus a measurement of results is difficult. At a recent session of the American Public Health Association, our Commissioner of Health cited the following accomplishments [9]:

—More than 2,500 applications to establish or construct hospital facilities have been processed, and these involved 20,000 hospital beds, 48,000 nursing home beds, 18,000 health-related facility beds, and 600 ambulatory care projects. From these applications 10 percent, or 2,000 hospital beds, and 35 percent, or 16,000 nursing home beds, have been disapproved on the basis of no evidence of need;

—Since construction standards were set, 31 hospitals with over 3,000 beds not conforming to these standards have been closed. Also, 183

non-conforming nursing homes with 4,500 beds have been closed;

—In 1966, 40 percent of the nursing home beds were substandard; today, slightly over 10 percent are still substandard.

—Nearly 1,400 maternity beds have been converted to other needed uses.

Certain other statistics are also impressive. At a time of low utilization nationwide, New York’s experience is contrary. The utilization rate for general hospitals in the State in 1971 was 79.4 percent and for nursing homes, it was higher at 90 percent. Both are generally accepted optimum rates and represent improvements since 1966; the hospital rate then was 76.7 percent. Yet another interesting statistic may be cited: New York’s ratio is one hospital to each 53,000 residents compared with the national ratio of one to 35,000.

Still in the way of introduction, it may be of value to briefly present an overview of New York’s Article 28 procedure. Simply stated, a new health facility must, prior to its establishment, be approved by the State’s Public Health Council. This approval must also be given to an existing facility which proposes to change its basic service such as the conversion of an acute care hospital to a nursing home or a site change which would place a hospital in a different service area. In reaching its decision, the Public Health Council considers the public need, the character and competence of the sponsors of the proposed health facility, the adequacy of the finances for the facility, and the reasonableness of the estimated costs of the service of the facility once in operation. In its considerations, the Council solicits, and usually receives, assessments from the local planning organizations, the State Health Department, and the State Hospital Review and Planning Council.

The latter council, while an equal to the Public Health Council in that both are gubernatorially appointed and both serve in advisory capacities to the Commissioner of Health, differs in that it plays an important role in construction projects for *existing* health facilities. However, it has no formal approval power over such projects; that is reserved to the State Commissioner of Health.

Please note that the authority of the Public Health Council is limited to the actual “establishment” of a health care facility. Once that body approves such establishment, the State



Hospital Review and Planning Council takes over. As this paper will subsequently emphasize, the State Commissioner of Health has significant power in the certification of need process with the exception of establishment. The State Legislature reserved this to the Public Health Council.

I have now completed all the references I shall make to the Public Health Council. Hereafter, when I use the term "council," I refer to the State Hospital Review and Planning Council. That group has the responsibility of reviewing all projects of substantial construction, alteration, reconstruction, improvement, extension, or modification of a health care facility. In this review, as we shall see in more detail, the council receives considerable aid through the seven regional hospital planning groups in these undertakings. This help is needed since there are nearly 1,600 health care facilities in New York for which the Commissioner has responsibility under Article 28. Once the council completes its review, it makes its recommendations to the Commissioner of Health who then approves or disapproves.

I used the word "substantial" in describing projects requiring approval. This infers some and not substantial and thus are exempt from the certification procedure. In general, a project is not substantial if: (1) its costs do not exceed \$50,000; *and* the facility's bed complement or services do not change; *and* the project is not in violation of the State Hospital Code which is an extensive set of regulations developed by the State Health Department to implement the planning law.

Having said all of the foregoing, I shall now, as promised, turn to a discussion of the AHA's *Guidelines for Implementation of Certification of Need for Health Care Facilities and Services*.

#### *Purpose*

The first major AHA guideline relates to the purpose of certification of need. To quote: "(the) purpose is to insure a defined community of the availability, accessibility, and viability of comprehensive quality services [10]. New York's Article 28 purpose is almost as sanctimonious but is inclined to reflect a greater sense of control. It states: "Hospital and related services of the highest quality, efficiently provided and properly utilized at a reasonable cost, are a vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the Department

of Health should have the . . . responsibility for . . . the State's policy with respect to hospital and related services." One may gather from this that the Commissioner of Health also exerts significant influence over hospital costs. This is true. In a separate section of Article 28, authority is given to the Commissioner to control Medicaid and Blue Cross rates of reimbursement which represent approximately 60 percent of hospital revenues in our state. As I will describe shortly, this fiscal power is often exercised to control construction.

#### *Coverage*

The second major AHA guideline describes scope of coverage. The guideline as stated is quite encompassing and excludes only the medical practitioner who pursues his profession independent of a health care institution. New York's law is almost as comprehensive; however, federal hospitals, notably those operated by the Veterans Administration, and mental institutions are excluded from coverage under Article 28. Virtually all psychiatric institutions in New York are operated by the State's Department of Mental Hygiene. Since 1966, the only significant problem on coverage arose after passage of New York's controversial abortion law in 1970. At that time, abortion clinics were being established in motels in some parts of New York State. Legal questions were raised as to whether these fell under Article 28; subsequently, it was resolved that the Commissioner of Health did indeed have regulatory authority over them [11].

#### *Responsibility*

The third significant guideline in the AHA document gives considerable power to government when it notes that "The State government should have the ultimate responsibility for the operational aspects of the certification program [12]." State government is emphasized; federal government and voluntary controls are not. This guideline notes further that local areawide health planning agencies, if they exist, should have a role. New York State government has solid control over its certification of need program. However, local planning agencies do have a definite role. The State law is quite specific in requiring that the Commissioner not act upon an application for construction until the local planning agency has had a reasonable time in which to submit its recommendations.

Much of the success of New York's program is due to the extensive investigative work done by the seven local planning councils. It is at this level where true comprehensive health planning is really applied. Personnel in these local groups, both employed and voluntary, extensively assist project sponsors in determining not only the need for their programs but the appropriate size and scope of the project and the relationship with other health services in the region. It is at this level that the projects are exhaustively reviewed and evaluated. Every opportunity is afforded all interested groups and people to present their views; sensitivity to local needs and aspirations is well exercised. Financing of the seven regional councils is largely voluntary. The state provides about 25 percent of the total monies necessary; the balance comes from local sources including industry and the hospitals themselves.

#### *Authority*

Principle four in the AHA document suggests that authority should be vested in a single state agency. In New York, this is the Commissioner of Health and his Department. Acting in an advisory capacity is the State Hospital Review and Planning Council. Seldom does the Commissioner act without the recommendation of this council and, to date, he has rejected only three recommendations of that group out of about 3,000 submitted.

#### *Progress*

The next AHA guideline recommends that the certification of need process involve at least two steps. The first is a notice of intention and the second is final approval prior to actual construction or the acquiring of new personnel or equipment in instances not involving construction. This guideline seems to have been almost lifted verbatim from New York's Article 28. A two-part application is involved. Part one, which includes information pertaining to the type of facility proposed, the estimated cost, the means of financing, and a description of the operation of the facility once completed, is forwarded to the local planning agency and the Department of Health for evaluation. Recommendations from these two groups are forwarded to the State Hospital Review and Planning Council. Approval or disapproval is then given to the proposal by the Commissioner. If approval is gained, the second part of the application relative to the

project concept is prepared. This part largely includes architectural interpretations of Part 1 and includes the bulk of the architectural and engineering portions. Even during the construction stage, there must be a final inspection by the Department of Health. This normally occurs at a 95 percent completion stage.

#### *Requirement for Services*

The next guideline, Number 6, appears to be one which sounds good, but in application, is difficult. It holds that the certification of need agency should have the authority to require essential services. In New York, the Commissioner of Health does indeed have such authority but it is largely applied indirectly. One method used is a document which I mentioned earlier; an administrative law called the State Hospital Code. In this Code, the Commissioner describes in great detail how health facilities shall operate.

To enforce its provisions, Department survey teams visit hospitals to determine compliance. At the conclusion of the survey, a critique is prepared by the team and presented to the administrator and his governing board. The administrator is required to respond with regard to deficiencies. Given a sufficient number of such surveys, and they are conducted about once every six months, an administrator is often pressured into correcting these deficiencies to avoid being held accountable for not doing so before his governing board and, perhaps, the Commissioner of Health. Obviously, the best time to influence an institution to implement a service is at the time of initial establishment of the facility or at the time an existing facility wants to make changes. The Commissioner may use the opportunity to strongly suggest that a service he deems important be implemented.

It may be noted here that some in New York State question the continued need for inspections by the Joint Commission on the Accreditation of Hospitals in addition to those conducted by the State Department of Health. Efforts are underway to coordinate these two programs to reduce the areas of duplication. The confidentiality of the JCAH information is, however, a difficulty; but we hope to resolve that. The State appears to be willing to accept parts of the JCAH inspections thus eliminating at least a portion of its survey. The two programs will continue in New York and will eventually complement each other.

### *Discontinuance of Services*

The next AHA guideline is addressed to the discontinuance of services. While the surveys described above may be influential in this regard, financial penalties are much more telling. For example, if an obstetrical unit is underutilized, the Commissioner will reduce reimbursement under the Title XIX and Blue Cross programs which he controls. Thus, a health care institution may continue to operate an unnecessary service, but financial support for it may be difficult.

One of the most striking fiscal controls used by the Department of Health is a requirement that depreciation be funded. Each facility must put aside that portion of its reimbursement from all sources which represents depreciation. If it does not, the Commissioner will reduce the Blue Cross and Medicaid rates by that portion which was not funded. Payments made to amortize debt is considered to be funding; also, an institution may request a waiver of this requirement. It is usually granted only if patient care will be adversely affected by the lack of these funds. Through this method, the Department assures that monies for replacement will be available in the future or, if a facility is so financially inept that it cannot fund, it will close in part or in whole.

While on the subject of controls through monetary pressures, it may be well to note that H.R. 1, now before the Congress, contains a section which would limit federal financial participation in capital costs to those which are consistent with regulations of state planning agencies. The bill authorizes the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts for depreciation, interest, and in the case of proprietary providers, a return on equity capital if these expenditures are determined to be inconsistent with state plans [13].

### *Public Hearings*

The next major AHA guideline is a requirement for public hearings. It holds there should be an opportunity for public hearings on every application as well as hearings on standards and regulations before they are adopted. The Article 28 regulations in New York provide that a facility may have a public hearing only if its application is disapproved by the Commissioner. On a regional level, public hearings are optional;

more often they are unnecessary because the regional planning agencies include broad representation from the community. No public hearings are held with regard to standards or regulations. Rather, the State Hospital Review and Planning Council considers them and passes on its recommendations to the Commissioner.

### *Financing*

The last major AHA guideline notes that the certifying agency should not be involved in financing of facilities, unless it has required a change in the services provided. Application of this principle in New York would be difficult since the certifying agency—the Commissioner of Health—also controls reimbursement. Following approval of a project by the appropriate division within the Department, the applicant must then move on to another division where he negotiates for a rate of reimbursement to fiscally support the project. Thus, it can happen that a project receives planning approval, but is not given sufficient fiscal support by another arm of the same agency.

We are now at the point in New York where the need for general acute care beds has been met, at least through 1975. It remains now to correct maldistribution, to replace substandard beds, and to encourage mergers which will not result in a net gain of beds. Accordingly, the State has adopted policies designed to meet these ends; it is referred to as a "freeze" on beds.

By most measurements, the certification of need process as measured by New York's experiences, has worked. Utilization rates have held; the distribution of beds per 1,000 patients is fairly uniform statewide (only four counties out of 63 have less than 75 percent of their requirements satisfied); substandard beds are at a minimum; and profiteering is almost nonexistent. On the negative side, there has been no noticeable effect on costs when New York is compared to the rest of the country. But, then, perhaps costs would have been higher without the construction controls.

In summary, I suggest that a certification of need system structured along the AHA guidelines would be of benefit and in the best interests of hospitals. Those states without control laws should investigate that document. Our

initiatives, however, should not stop there. More external controls are facing us as the upcoming discussion on national health insurance will emphasize. It remains for the hospital industry to be directly involved in their development. We have a reputation for being status quo minded while progress demands change. We must change our spots.

That concludes my remarks. I am reminded of a quote from Yogi Berra which may not be inapplicable here. He was asked to comment on how-it was that when the Athletics moved to Kansas City, few came out to watch them play—the stadium was usually empty. Yogi responded, “Well, if the folks in Kansas City don’t want to come out and support their ball club, you can’t stop them.” Let’s not be like the folks in Kansas City.

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CHAIRMAN MAY: Thank you very much, George. Are there any questions?

#### QUESTION AND ANSWER SESSION

MR. ODIN ANDERSON: Speaking of stopping, in the New York situation I gather what it has been doing is to stop something from starting. Can you start something where it is needed, or do you have to simply hope for a spillover?

MR. ALLEN: You are right. The approach has been to stop something before it started. As far as starting something that is needed, in other words trying to generate initiative in the community to establish some kind of facility, that is not easy.

MR. ANDERSON: Do you worry about it?

MR. ALLEN: It doesn’t happen very often. Although the Commissioner does try, when he sends surveyors into the hospitals under this inspection situation, he may well cite in the deficiencies that an outpatient clinic is needed where one does not now exist. He can’t order the hospital to put it in, but he will say to the administrator, “You really ought to have it”, and that report goes to the hospital’s board. If he keeps suggesting it enough, somebody is going to get the impression that maybe that ought to be done. That is generally the way it works.

MR. ANDERSON: Another reason for asking my question is that theoretically, I suppose, we don’t have an inexhaustible supply of local initia-

tive which if sat upon often enough will say, "To hell with it. Why should we try?"

MR. ALLEN: It largely exists, interestingly enough, in the suburban hospitals. If you look at the Hill-Burton problem we are in right now—and how many of you have seen the posting in the Federal Register where Hill-Burton hospitals have to provide 5 percent of their operating costs in free care—when we analyze that we find that most of the city hospitals are way above that (and most of the suburban hospitals are not) because the city hospitals have taken the initiative to go out into the community and set up clinics to provide services to the poor. The suburban hospitals simply have not, and perhaps the poor in the suburban areas, or the indigent there, are medically poorer than they are in the cities these days. We are still measuring this, but we are becoming increasingly surprised that that is indeed a fact. I think it is a black mark on those communities that that type of thing does exist.

QUESTION: When you make the statement that there is a freeze on adding acute care beds, can you then assume that there is no maldistribution of acute care beds?

MR. ALLEN: I tried to explain that. You could add acute care beds as long as there was an offsetting closing of acute care beds in some other area. That would try to correct the maldistribution. The maldistribution does exist particularly on Long Island. When Nassau and Suffolk Counties are really burgeoning in population—I think the number of beds is something around 2.8 compared to 5.0 per 1,000 in New York City. The idea then is to try to close some in New York City and open some in Nassau-Suffolk. Yes, there is a definite attempt by the State.

QUESTION: Practically all of our planning at this stage is retrospective planning. We have to have a level of occupancy or utilization, anything from one year or two on up, before you can get into the planning function, really. Is there any thought in the setup in New York to go to prospective planning, such as the utilities do, that you look five or ten or twenty years ahead and you are going to have to have this much generating power by 1980, and therefore you are getting on line with it?

MR. ALLEN: Yes, perhaps more theoretical than practical at the moment, and it is largely through the 314 A agency and the B agencies. I mentioned the local planning councils. The majority of these are not B agencies. These are just coming into their own in New York, and it is in these and the parent A agency at the state level where this type of prospective planning is being done. They are trying to define the needs of the state in the next twenty years. Boy, that's terribly difficult, given the political climate and the constant change in the fiscal policies of the state.

It is almost impossible for administrators in New York and a lot of other states now to plan at all, because they don't know what their income is going to be from day to day, much less next year or the year after; and they can go ahead and plan for the needs of the community, but then they find that the money is simply not there.

REMARK: Isn't this where we get with this whole bit if we have to do this totally retrospectively and can't do it? I agree, we don't really have the measures in order to be able to predict and judge it. If we don't develop those, then we are in critical situations where we have the kind of thing you mentioned in your couple of counties, or where the federal government decides to put in a big installation and move a population in in a hurry, or where there is a natural shift just because of people's desire to move to more desirable neighborhoods.

MR. ALLEN: That is why planning both construction control and true comprehensive planning and fiscal control, and operating standards and practices and licensure all have to be brought together into some type of single commission or single agency, like a public utility commission. Right now in most of the states, and even nationally, these things are fragmented. We have to bring them all together.

CHAIRMAN MAY: I think your point is complicated by the fact that if I start now thinking about providing some beds, it is going to be 48 months before I get them operating smoothly anyhow, and that is 1976.

REMARK: That is all the more reason why you have to do prospective planning; and it is some-

what easier, I guess, when you can talk about kilowatts and the relationship to a family unit or to an industrial unit and their use of it. This gets crazy when somebody comes along and develops open heart surgery and you didn't have it five years ago, and now you suddenly have to get on line. I just don't see any sophistication coming out of the universities or anywhere else to tell us how to do prospective planning in the health field.

MR. ALLEN: One of the elements you are leaving out is the physician. He is the one who brings that pressure in heart surgery.

REMARK: Or the public that puts the pressure on the physician or community to have that kind of facility. We have seen it within nine months of each other. One community gets it, and the next community says, "My goodness, we have to have this too."

REMARK: One of the things about trying to analogize to planning for public utilities, as opposed to the hospitals, is that there is a kind of cross-subsidy effect that goes on in terms of utility planning, and that is subsidizing in areas that don't use a great deal of electricity, for instance, that supposedly will be populated in ten years, and you move lines in there and they are subsidized by heavy using areas in the rates they have to have. That is one form of prospective planning.

In the hospitals it is not clear that that money will go to those hospitals to in effect subsidize an under-used hospital in an area that will be burgeoning in ten years but right now is not very populated. So, it is not just a planning question but it is a question of financing, and how much present users in populated areas are willing to subsidize under-populated areas, and areas where utilization may not be as great.

REMARK: It seems to me very disappointing that in this country, when we have so much regional and other planning, we talk about planning in the hospital field and health care. That planning did include the entire need for services, including hospitals, education, housing, and whatnot. In your State of New York there is an experiment going on in a very unique way, developing communities and providing all facilities. I don't know to what extent your coordination is established with that.

MR. ALLEN: Hospitals, at least from my experience, play a very minor role in comprehensive planning and the development of community facilities, other than in the direct acute problem areas. For example—and again only drawing on New York State—when a hospital tries to develop extended care facilities and nursing home facilities as part of the hospital, to try to give a complete comprehensive care, eventually the acute care patients end up in those extended care beds and the hospital still remains an acute care facility.

As a trade association we have not been at all involved in the development of education, in the development of housing, in the development of antipollution policies, not at all. That is probably because we are a hospital-oriented association, and this may be too an indictment of the American Hospital Association.

There is a great deal of discussion going on about changing that type of organization into one which is concerned with broad health problems. If the association were changed, perhaps its constituency and members would change too, but I haven't seen it yet. Hospitals usually live from hand to mouth, and really don't get involved in very much comprehensive planning at all.

QUESTION: From your comments it seems clear that New York State has developed some very specific and detailed standards as to how much is enough—how many beds. Will you comment on how those were developed, and how really tight they are?

MR. ALLEN: They are very tight. They were developed simply by hiring a lot of darned good planning professionals in the State Department of Health and in the local planning councils. We have some excellent planning professionals who work on this, and the key to it, I guess, is that they work with the hospital administrator in developing the needs for that hospital. Whenever the administrator gets an idea he has to run through these professionals first. The answer is good, competent people.

CHAIRMAN MAY: I think New York must contain every planning professional in the world who is willing to make a decision.

QUESTION: Are you saying that there are so many beds per 100,000 needed everywhere in

the State, or do you do it specifically for an area?

MR. ALLEN: It is area-wide planning. Different standards in different areas, yes, including not just beds but ambulatory care facilities too, and need for nursing homes and extended care facilities, and on and on. It isn't just limited to acute care beds.

QUESTION: Is there any kind of trend on the part of the administrative people toward resentment of the Commissioner of Health because of the tremendous amount of authority he has, or is there a passiveness developing, and sitting back and saying, "That's that?" What is the thinking?

MR. ALLEN: There is antagonism when the Commissioner gets into the area of money control. In this whole field of planning control, there is none. The cooperation is excellent, by and large, even though sometimes there is a little goring as pet projects go on. Largely there is an excellent relationship.

When you get into the control of the hospital's

money, then I think we have a great number of problems. The fact that he controls Blue Cross particularly aggravates hospitals in the State, and he constantly sets the prospective rates of reimbursement below the hospitals' costs in order to force them to bring them down.

Let me get into prospective rating in New York. It is interesting. I mentioned 60 percent of the revenues are controlled by the Commissioner. What he does is set an all-inclusive per diem rate for each hospital in the State, one for Medicaid and one for Blue Cross, and says, "That is what the hospital is going to get. We will only change that if new services are added. We will drop it if you phase out some services."

The other time it changes is when Leon Davis gets active in New York City and negotiates a lucrative contract. Then the Commissioner is hard put not to adjust the rates.

You can imagine an administrator waiting for the rate to come out, and then realizing it is not enough, and not being able to do anything. That is frustrating, and you have to use the Commissioner's name in vain.

## PANEL DISCUSSION

# Implications for Hospitals of Currently Proposed Health Insurance Legislation

JOEL MAY, *Moderator*

*Panel members:*

ODIN W. ANDERSON, *Professor, Graduate School of Business and Department of Sociology; and Director, Center for Health Administration Studies.*

JAY HEDGEPEETH, *General Counsel, American Hospital Association.*

GEORGE B. ALLEN, *Executive Vice-President, Hospital Association of New York State.*

CHAIRMAN MAY: The ACHA, about ten months ago, appointed a Commission to study the implications of national health insurance for hospital administrators, and the panel this morning originally was designed to examine what the thinking has been in this area to date.

Odin Anderson, who is on the panel, is the person responsible for preparing the report for the Commission, and is well along in developing the thinking in this area. However, the way things have worked out—that is, with two of the three scheduled panel members not being able to attend—we are going to take a slightly different slant, and Odin is flexible enough to fit into the new format.

Jim Ludlam and Stan Martin both send their regrets. Neither could make it today because of the press of duties. We are fortunate, though, in having Jay Hedgepeth, who is Chief Legal Counsel of the American Hospital Association, filling in for Jim at his suggestion. George Allen has agreed to stay on and to field the questions that he didn't field this morning, and also to comment on this more general issue.

What I would like to suggest is that Odin and Jay take about ten minutes each to talk about what you have heard and what you have been thinking about in this area, precipitating a range of questions, and then we will throw it open and anything is fair game.

Whereas we had three success stories in prospective budgeting yesterday, Jay may be able to give us a little perspective on some of the

problems involved in operating one, and some of the questions might involve that.

Odin Anderson, will you start?

MR. ANDERSON: In this audience almost all of you are alumni, and some of you are current students and are conceivably thinking, "I suppose he will say the same old thing he said last year." There are some recent students here who will realize what you have forgotten. The mature and older students never knew it in the first place. So, I will work from there.

What we have been observing in the last day and a half, and what has been alluded to in the tone that I want to talk within this morning, and with Larry Hill, is that I think there is a tremendous lack of candor in discussing these problems. We don't go beyond the surface as to why we say what we do or what we think. We assume we have rational reasons for doing this and that within the political system. Really, what we are doing (and I think this is legitimate because this is in large part what life is about) is that we play games. We ought to call them games. I am enough of a puritan to recognize things for what they are. So, we are in a political struggle. Larry Hill called it a war. Well, if so, it has the lowest casualty rate I have ever heard of. There are just bruised personalities, tempers, and so on but no premature deaths.

What we are doing, of course, particularly during the last ten years, let's say, or more specifically since 1965, is defining what kind



of an arena we are working in. We are trying to figure out who the major interest groups are, the major partisan interests, how much power they have, what they want, what we can give, what we can trade off, and so on. We are trying to get at some rules of the game because, as I have said over and over again, this field lacks so many specifications for performance.

Lacking indicators for performance as to what is proper quality, proper use, proper facilities, not to mention proper expenditures, then eventually, given the tremendous public interest with which this field is imbued, naturally it becomes politicized because we have to enter into a bargaining and negotiating situation, and all the parties at interest are trying to figure out what the particular power constellation may be. Of course, we believe we are working for a larger goal in the public interest.

Apropos of that, and I think relevant, in the last week I read a book very carefully (suggested by my wife, incidentally,) called *The Intimate Enemy—How to Fight Fair in Love and Marriage*. This book has much wider ramifications. It dealt with inherent conflict situations, which most of life is, and in what are the methods of sparring and leveling, the expression used, leveling with each other as we try to work out rules of the game.

George Allen told us about New York. Someone told us about New Jersey. Somebody else told us about Rhode Island. We are talking about a negotiating process. People like administrators in many miserable instances are pushed back to explain what is inexplicable. How can you tell politicians or policymakers what quality is, and trade off between quality and money, or really what the occupancy rate should be, and so on? So, it is a fallacy of assuming that you know in any systematic terms what efficiency is, or that you know what proper use is, or adequate staffing, and so on.

This really becomes points of equilibrium between the forces in the health services system. This is inherently peculiar to the American scene. Every place I have been, there generically this same kind of problem. These problems are wrestled with in different contexts, and varying from our very sort of open, still open and loose system, to a very highly structured kind of system that you find in Great Britain, and other countries in the Western world are more or less in between. Nobody knows really what they are doing anywhere, actually, other than that the systems are functioning. Millions of

patients enter and are discharged with a very low death rate, and then the performance indicators become social and political criteria as to the nature and degree of the access of patients from various income groups, and also how the costs are shared more or less equitably through the body politic.

So, Hinderer tried to set up a sort of pure market concept, and wished we were rational enough to work within it. Dennis May began to move toward a political and social context, and Hill came right out and said we are in a war. Well, given what he said about his experience in Rhode Island, I can see why he thought so.

Further, as we move into the various national health insurance proposals we encounter, then, as you all know, a great range, from a very highly structured kind of concept, as embodied in the Kennedy bill, to one that is a simple income transfer and/or a catastrophic coverage with no intent to have national leverages on the system as exemplified in the Long bill or the AMA Medcredit bill.

As you look carefully at all these measures, you can throw them into types. It seems to me the Administration bill is more or less in between all of them. You can see, then, reflected in the bills, how you might function or what implications there are for the hospitals as autonomous or not autonomous units, as the case may be, depending on the bill that will come out, and to what extent you can continue to function as professional managers, as entrepreneurs, in your own right.

I happen to subscribe to the entrepreneur concept for all managers, no matter what the enterprise is, in order to have some dynamism in the system, so that you should have some control over various sources of funding and so you can manipulate the funding and not have most of it come from one source, because the poor Commissioner of Health in New York State knows less about it than you do. But somebody presumably has to do something, so he may behave like a father whipping his boy and saying, "This hurts me more than it hurts you." Does the Commissioner say that, George?

Still he probably enjoys it, because there is power. So, I would hope we can move into a system where you have these contending adversaries, the intimate enemy, really, because you

are so close to each other and all working in the public interest.

So, I hope the health administrators through the various organizations you have, particularly the American College of Health Administrators, would be intelligently aggressive in moving in for your own interest and for the interest of your hospital and for the interest of the public, as these rules and regulations and the context in which we will be doing our work for the next ten or fifteen years are hammered out.

I suppose we haven't really met a real crunch yet, because when I listen to the estimates of what has been "saved," or George Allen's number of beds—35 percent of the nursing home beds—financially it seems to me there was 4 or 5 percent. I suppose these small percentages are politically tolerable, and we are operating at a fairly high level of flushness in the system, but at the same time if it is politically feasible I suppose we should continue to work for what I like to call a generously proportioned and generously financed system within which we hammer out the various options or delivery methods within a context of relatively good supply. If we move into a period where we have a small supply and little money, it is going to be easy to plan then, because there isn't much to plan with, and it becomes quite self-evident as to what you should do.

I would also feel that if we do move into a more tightly financed system, more tightly controlled, without real systematic knowledge of what is going on, the health system will bulge out into a fairly flush and large private system, because I can't see this system in the foreseeable future proscribing the private sector from developing. Since the government in this country is so reluctant so far to own anything it would rather buy, regulate, and what-have-you.

I will end with something that has become an appendix to my bible, which is one of the nine laws of the disillusioned liberal, was promulgated by a sociologist by the name of Levy, I believe at Yale.

"Always pray that your opposition be wicked. In wickedness there is a strong strain toward rationality. Therefore there is always the possibility in theory of handling the wicked by out-thinking them. Good intentions randomize behavior. Subcorollary 1: Good intentions are far more difficult to cope with than malicious behavior. Corollary 2: If good intentions are combined with stupidity, it is impossible to out-think them."

This is the politics of health planning.

CHAIRMAN MAY: Now, Jay Hedgepeth.

MR. JAY HEDGEPEETH: As you may know (or perhaps it never occurred to you), a lawyer specializes in the type of business that walks in his door, and so it is thus a strange coincidence that during the major part of my private practice of law I was involved in both health law and another subject that seemed entirely disconnected, at the beginning stages at least—the matter of public utility regulation. During the course of time that I pursued both endeavors, it gradually came to dawn on me that perhaps there should be a relationship between the two. But I assumed that that was primarily due to my own personal perspective, and that no one else would ever be convinced that the two should come together.

Imagine my surprise, when on first appearing on the scene with the American Hospital Association, my first day's duty was a board meeting at which was presented the Perloff Committee Report, that embraced within it the first major recommendation for a combination of health care with a certificate of need process and rate regulation.

Also, I found there had been under way for quite some time a panel of health care experts, including public utility experts from the Public Utility Commission of California and A. J. G. Priest, who was referred to by George Allen earlier. It was my opportunity to help staff that committee, and the panel ultimately produced the recommendation that George Allen also referred to that was presented for consideration by the health care field.

Some 7,000 copies of that recommendation that there should be consideration given toward public utility type regulation to health care delivery were distributed, with the ardent request that people forward back comments, suggestions, criticisms, and so on.

Apparently it wasn't too much read, for, rather than receiving immediate protest or complaint, three specific responses were received. Two of them were unfavorable—and incidentally they came from the same office. From that point perhaps the Association was encouraged to go forward and produce the two documents, one on certificate of need and the other on rate regulation. There are of course vital considerations being given to those two programs. Many state legislatures have in the meanwhile adopted different programs.

Joel May earlier referred to the Ullman bill, H.R. 14140, which is one of the several national

health care programs now before Congress. It combines, of course, the principles that we have referred to. Congressman Ullman gives credit to the American Hospital Association for some input. It involves certificate of need, rate regulation, surveillance of quality of care, and a desire for a better distribution of health care personnel.

I would like to discuss some of these aspects in the light of what you have been considering in the last two days. I might mention this, too: I am sure that the hospital field, in turning toward public utility regulation, was thinking completely of the public interest. But they also had, I think, seen the writing on the wall, perhaps in New York State, where the impetus for regulation of this type had not come from the health care field, and in other areas where the effort was not so much for constructive development and planning as it was in placing shackles on an industry that apparently was unable to regulate itself. So, in primis, if the health care field had been satisfactorily handling its affairs, we would not be having the subject of your discussion today and yesterday.

Let's consider some of the aspects. I might say that I have indicated my own bias. It would appear that certificate of need regulation along the utility model and rate regulation along the utility model would be advisable, but I am not about to say that they would be without problems. Let's tick off just a few of them that are worth considering.

First, should this be combined—a certificate of need commission with a rate regulation commission? This is not done in New York State. Some people suggest that this gives an opportunity for a whipsaw effect. You may get your certificate, but you may not get the corresponding rate that you need to go with it.

I might suggest that if you are absolutely faced with having two commissions, perhaps the problem of having dual regulation could be aided if your regulatory scheme provided that at least a certificate of need finding by the one board would be conclusive, on the rate regulatory board, that this was a proper function and duty of the institution that had to be funded.

Another important aspect is what should this certificate of need legislation cover. Obviously, we think it should cover hospitals; it should cover nursing homes. But how about the other aspects? For instance, if a hospital in a given community seeks to install cobalt therapy equipment, and after due hearing the certificate of need commission determines that it is not appropriate; if your legislative scheme is not

broad enough, what is to prevent the radiologist from installing the same equipment in the same community in his own private clinic? Do you have any beneficial effect, then, from this type of certification? So, it would appear that any type of regulation must include those aspects of other health endeavors that have the potential of harmful duplication that would be prohibited by a hospital institution itself.

Originally, many people of course thought of this as a regulation on the number of beds. But then it became apparent that services also should be included. Further, it became apparent that there should be some territorial area (perhaps this was borrowed from the public utility field) that should be applicable to the regulated institutions. It would appear to me that this territorial aspect and the service aspect will, in all likelihood in the well-regulated state, involve what I would call the Ballantine syndrome. You may remember the trademark that includes the three overlapping rings. In this way a certificate for one purpose might extend in this area, for another purpose in this area, and you will have overlapping of course in at least a central area. This is one item that must be kept in mind particularly in the metropolitan areas.

Another thing to be considered is the matter of existing facilities. These must be taken into account not only to protect those in the field but also to avoid the uneconomic duplication that the very process is to avoid.

Another thing to be considered is the matter of regulation by bits and pieces. Someone mentioned that under the state regulatory system in his state an expenditure originally of \$5,000 had to be certificated. Later that was made more liberal, to the extent of \$15,000. Some of you may even disagree (and George Allen may himself) with the appropriateness of a \$50,000 exemption; but it should be pointed out that regardless of your exemption in funds that may be involved, there will be a necessity for continually coming back to the Commission to ask for authority to furnish a new service or to construct a new facility.

Another aspect that should be considered in this entire system, that has not yet been fully developed, is the adversary system that is apparent in the public utility field. As you may be well aware, many public utilities, although granted monopolies for certain purposes, are in

direct competition with one another. Frequently they seek the same authority to perform the same service or to construct the same facility. Each of them contends that it is the best able to equip and the most logical applicant for this service.

I would suggest that in due time, as we gain experience, perhaps one of the best contributions that will be made to the entire field will be the adversary system, as rival applicants seek each to establish to the satisfaction of the Commission that they themselves are the appropriate party to provide a new facility or a new service. This, I might add, will produce constructive results and will also—perhaps, I feel I should warn you—provide full employment for the members of the Bar.

Another matter to be considered along with the certificate of need is the very vital issue of the rate problem. Where will you get the funds with which to rate your institution? There has been much discussion about the advisability of rate making and the problems that go with it. There also has been discussion about the matter of subsidization of certain services within an institution. I am reminded of a recent news release here in the city of Chicago, where one institution had drastically reduced the charges for services in a maternity center, presumably not to get a more realistic reimbursement, but instead to offer a subsidy and to place the service within the financial reach of the members of the community. The result, of course, is that other services of that institution must subsidize that service whose rate has been reduced.

There will be some subsidization, but it is to be remembered that with a regulatory Commission this will be restricted, and sometimes it may not be available when the institution thinks it appropriate.

Also with regard to the expenses that should go into a rate base, you will find yourselves in disagreement with any regulatory body from time to time as to whether or not an expense not only is justified but also whether or not the amount is reasonable. In this respect the public utilities commissions have found a very easy means of resolving this problem. They say, "You may expend what you will, but we will include as part of your rate base only that part that is reasonable, otherwise your additional expenditure must come from anticipated dividends to stockholders or even from a dilution of capital."

So, we face the fact that our expenses will

be fettered; our expenditures will be controlled.

The question then is: Is it appropriate? A system has been described to us. It has been criticized as lacking in due process. One of the major factors of the public utility model is the fact that historically it has afforded due process, the right to public hearings, the right to an appeal, and courts that still read portions of the constitution that contain phrases like "due process" and that there will be "no taking of property for public use without just compensation." So, a system that gives specific criteria, specific procedures, will be onerous. It will keep you and your attorneys busy, but at the same time it will protect the vital interests of your institution.

Another little windfall that will come from this model that was alluded to earlier this morning is the fact that often an institution heretofore has constructed a facility or offered a service not so much because of its own planning process but in response to a public demand which, in its opinion, may or may not have been fully justified. The new type of regulation, if adopted in your state, will provide the institutions with a body to which it can pass the buck. "I am sorry; we would like to have open heart surgery here. It would be good to keep up with the community 20 miles away or the institution 5 blocks away, but we simply cannot justify it to the Commission, and therefore we will take perhaps the same funds and provide another service that our planning group has advised us is essential and which we can justify to the Commission." So, in a way this new Commission will give you resistance to unreasoned public pressure and public demand, but more particularly it will give you due process.

An example has been given this morning of the opportunity—of regulatory bodies that are not affected strictly with due process—to lean on, to influence you, to decline to rule on one application unless you can be influenced to perform some new or different service that was not at all included in your planning. Due process will reduce the opportunity of any regulatory body to lean on you in a manner that cannot be supported by law or by reason or by evidence.

I was very flattered when Jim Ludlam asked me to appear. As you are well aware, he is a recognized authority on hospital law, based in California. The California Hospital Association, it should be noted, has not been backward. It has looked forward and has had public interest at heart; and therefore on a voluntary basis,

at the suggestion of the health field, they have come forward with various measures of regulation. It may be significant to you that the regulation that has resulted to date is considerably milder and less harsh than that proposed in other areas where the suggestion has come from outside the health field and has often been vindictive.

Thank you, Joel. If I have an opportunity to give a plug later on the new proposed Hill-Burton regulations, I would welcome the opportunity.

CHAIRMAN MAY: Do it now. For or against?

MR. HEDGEPEETH: Against.

CHAIRMAN MAY: What can you tell us about the new proposed Hill-Burton regulations?

MR. HEDGEPEETH: Someone mentioned earlier this morning that the new Hill-Burton regulations will of course require that an institution provide 5 percent of its annual budget, and health care services for those who are unable to pay for them, or 25 percent of the net, whichever is greater. If any of your institutions have been following the statement of financial requirements, you can guess which one will be greater. It will be 25 percent of net.

I think one of the most important aspects of the proposed regulations is the fact that they are and continue to be retroactive. They intend to prescribe new standards to replace the contractual assurances that Hill-Burton recipients have previously granted.

We would take the position that in so far as they would attempt to be retroactive, they would be prohibited by the Fifth Amendment of the Constitution, which, apart from criminal proceedings, of course, includes the protection against loss of property without due process, or taking of property for public use without just compensation. Also, the proposed regulations take no cognizance of the term of the obligation that has been inherent on Hill-Burton grants.

Another thing is that they take no cognizance as to previous recipients of the regulations in effect at the time, of the circumstances in effect at the time, of the guidelines in effect at the time the recipient signed the contract and agreed to furnish a reasonable volume of charity care.

Make no bones about it, there is an obligation of a reasonable volume of care; but that, it is submitted, needs to be determined from the

individual circumstances and the individual times of the various Hill-Burton grants.

CHAIRMAN MAY: What does all that mean to us as of May 18?

MR. ALLEN: We had better get an extension.

MR. HEDGEPEETH: The American Hospital Association, of course, has already indicated its dissatisfaction with the proposal, and it will have an opportunity to furnish a more extensive documentation of the different aspects of it, both from an equitable point of view, a fiscal point of view, and a legal point of view. Others of course will be doing likewise.

CHAIRMAN MAY: Any questions from the floor?

### QUESTION AND ANSWER SESSION

MR. ANDERSON: I want a clarification. He mentioned in New York State that you could not appeal. George, can that lack of appeal be appealed? Certainly you can litigate anything, I suppose. Can a state actually arbitrarily say there is no appeal? It says it, but can it get away with it?

MR. ALLEN: Let me clarify that a bit with a story, a reflection on your intimate enemy concept.

The Department of Health is a natural adversary of hospitals. Any regulatory agency is. I am not so sure in New York, because the Commissioner and I get along very well together. He asked me to be a consultant of his the last time I met with him—at least I think he did. After the meeting ended he turned to me and said, "If we want your advice again we will ask for it."

The matter of appeals as developed in the Commissioner's rules and regulations says in essence that if a hospital does not like its rate, it may appeal to the Commissioner, and he (this is a precise quote) "in his discretion may hold a hearing or may not," and after that the regulations are silent as to an appeal to a higher authority.

What usually happens is that the hospital appeals and the Commissioner turns it down

and says, "That's it," and directs the Medicaid agency and the Blue Cross agency simply not to pay the hospital the rate for which it appealed.

Since the law has been in effect since January 1970, not one single formal hearing on a rate appeal has been conducted by the Department of Health, nor has any litigation been placed or brought against the Commissioner under what we call an Article 78, where he is arbitrary and capricious in his decisions. The reason the Commissioner does not provide for appeals and hearings is that he has responsibility to control rates for 1,600 health care facilities, and it simply is impossible for him to do it. That is one of the many reasons why we think a public utility approach may end up being the best solution to the problems that we have.

Now that I have the floor, let me spend a few minutes on how I perceive the motivation is going to push us into a public utility approach.

The first thing that we see is the fragmentation of controls. As additional controls are put on hospitals, they are not brought together into any kind of organized thrust. We have controls on construction, yet after a project is approved that same agency has no obligation at all to insure that there is an adequate rate of reimbursement for the services. And indeed—and this is what Jay was talking about—you have to move to another agency to get that agency to get that money, and the two don't talk to each other. We have survey teams that go into the field and look at the practices of hospitals, and criticize them and say, "You should hire three or four additional people, more nurses," and so on, yet the rate agency that pays the hospital is not beholden to increase the rate to accommodate these orders from the surveying team.

Yet another example, talking about the concept of public utility now, is an agency in New York that can sell bonds for hospital construction, yet again the rate-setting agency does not work with that bonding agency to set rates of reimbursement, which would include the amortization of the debt. The hospital continually has to go with hat in hand, like a kind of dignified beggar, while we are being forced on the other side to put all of these into effect.

The matter of licensure is also another one of these controls where we are fragmented. The Department of Education is completely separate from the Department of Health, and is increasing the licensure requirements and making it a seller's market. Technologists, and so on, now must be licensed, and they are going to hold hospitals up for more money, and so on, and

yet again the rate-setting agency is not involved in all of this.

All of the fragmentation of regulation controls must be brought together into one single agency which has total responsibility for all of it, and probably most important also responsibility for the quality of care that is rendered by the institutions that it regulates. The departments and regulatory agencies simply do not face up to that.

Let me give you a couple of other examples that are pushing us into a public utility. One is the increasing movement of the physicians toward medical foundations. I don't know how many of you have been following that, but we view it with a great deal of concern in New York State, as these physicians are throwing up medical foundations as a way to counter government control. If they follow through with their total concept of the foundation, hospitals are going to be in a great deal of trouble in utilization and in their relationships with the medical staff. If we are really talking about the franchising approach, we have got to bring the physician very much into that picture.

The medical foundation is going quite the opposite way. Indeed, the nurses now, seeing on the scene the increasing militancy of the physician and the rise in the new situation of the physician's associate and physician's assistant—the nurses are getting militant, and they don't want to be employees of hospitals any more. They want to be independent of the physician, and broker their services to hospitals. Ultimately this will spread to other paraprofessionals. The administrator will be nothing more than a broker or agent for all of these services.

Another thing we see in this fragmentation is the Blue Cross people and the other purchasers of care now taking it upon themselves to set up HMOs and prepaid groups where we really don't think that is their area of responsibility, and hospitals ought to be doing it. But hospitals aren't, so these people are, as an effort to reduce their costs and to enhance their profits. All of this is fragmentation on both sides, and regulation, and the other people in the field doing these things have got to bring us together to some point where all of it comes to bear and total responsibility is there. I suggest that we must turn our efforts as hospital administrators and organizations to take the initiative and get in on the ground floor of this, or again we will be left holding the bag.

REMARK: I would suggest that the synthesized organization you are talking about is impossible

to achieve, in that you are going to have to departmentalize any agency that will have total responsibility. What you seem to be trying to develop is what I, under some coercion, have had to work with for two years, that being the department of medicine and surgery in the Navy. They do precisely what you are describing the Department of Health in the State of New York is doing. They have been doing it for years, and yet they do have total responsibility.

We receive our total budget from the same people who are telling us how we are supposed to be expanding our services or changing our services, and there are different people who make the separate decisions, and there is no correspondence between them. I think what you will end up with are forty or fifty departments of medicine and surgery, and they are no better to work with than what you have now.

MR. ALLEN: What I am really talking about is a single Commission where a hospital goes to in advance. These people are independent, not government officials. They are probably paid independent salaries financed from the hospitals, which is the concept of some of the public utilities now. There is no money problem. The hospital administrator comes before this Commission with his budget for the next two or three years, which includes his plans for services, and that Commission goes over that budget both in terms of the money it needs and planning approval, and then gives the whole thing its blessing, or somewhat modified, and guarantees that rate of reimbursement from all the third-party agencies, so that administrator and his hospital can perform with some degree of organization and reason.

Whether this is a single state Commission or set up on a regional basis, and what the priorities of geographic franchising are, remain to be solved. But what I am pitching for really is to bring all of this fragmented regulation into one single responsible organization which can be faced by the hospital in toto, so that he can operate.

REMARK: I would suggest you still would have the same problem. I think you are not being able to properly define what proper service is, what acceptable service is. You are going to have conflicting demands. On the one side you are going to be saying improved services make services more available, add more nurses to the floor, and on the other hand denying the kinds of financing you need to achieve it.

MR. ALLEN: Then we are down to what Odin is saying, and that is a process of negotiation. Perhaps in the long run that will be the best solution.

MR. HEDGEPEETH: There is one aspect of the public utility regulatory system that is helpful. They have a hearing body. They have a staff of experts who assist them. You also have the hearing process; and if there is anything any court or any commission does not like, it is the prospect of being reversed.

So, ordinarily they will undertake to make decisions that are irreversible by the courts. That is to say, they are decisions that are supported by evidence, logic and law, and this has a very beneficial effect.

MRS. ANNE SOMMERS: I would like to ask two questions. I am provoked to ask a couple of questions. I agree so much with what George Allen has just said about the implications of the foundation approach, and so forth. I don't think it has been adequately appreciated.

I would like to ask both George and Jay why hasn't the hospital industry taken a stronger position against the PSRO. This, it seems to me, is a complete threat to whatever integrity the hospital has now in the quality and utilization review area. That is my first question. Shall I wait for an answer to that?

MR. HEDGEPEETH: How about a quick one. It has opposed it. So far it has not been adopted.

MRS. SOMERS: Have you opposed it strongly?

MR. HEDGEPEETH: So far it seems to be adequate. How about your next question?

MR. ALLEN: Do you want me to comment on it? We have opposed it in application but not in principle. You really can't argue with the principle of it, and that is the judgment of utilization of professional standards. I think we are seeing a turn to reimbursement based on utilization and some kind of relationship to spell the episode of illness which is being proposed.

I guess really utilization committees in a lot of hospitals don't really work, because they are controlled by the medical staff. If we could get some type of system where utilization review has the input of the Blues, or the purchasers

of care, hospitals and physicians, we might be better off. The other reason we haven't proposed it strongly is because we leave such matters to the American Hospital Association.

MR. ANDERSON: Utilization review committees haven't worked because they didn't know how to do it. There is no methodology of the utilization review which has any professional meaning. We are being asked to do things that cannot be done at the moment. We are always being pushed into doing things that we don't know how to do.

MR. HEDGEPEETH: In some measure we are already doing it.

MR. ANDERSON: Yes, because we are fortunate in having been forced into having to do something. As I get older I have reversed the expression, "Don't just do something, stand there."

MRS. SOMERS: My second question: I would like to hear Jay's thinking on the concept of the adversary relationship of rival applicants as a possible counterweight to the concept of geographic exclusivity. This bothers me a great deal. It is one of the things that has held me back from moving faster toward a public utility approach.

I think it is terribly important. In fact, I don't see how you can really have effective planning and effective coordination if you don't have some sort of geographic definition. At the same time I, as a consumer, worry about the lack of choice to me involved in geographic exclusivity. When you speak of rival applicants, this is simply before the franchise or whatever it is granted. What about carrying that further and having some sort of overlapping franchises? Is there any experience in utility law that would permit this so that you would have perhaps a modified form of free choice?

MR. HEDGEPEETH: Yes, there is. I mentioned the Ballantine trademark. In a typical certified area there will be several such configurations that overlap one another. This will be in part recognition of existing facilities. Also, we have a particular parallel in the public utility regulation field from motor carriers, which often have the same routes, often have the same terminals; occasionally they will be restricted to a closed-door policy within a certain area. Frequently

a certain degree of competition is permitted.

Also, in other areas where fixed facilities are not quite as important, such as radiotelephone systems, a certain degree of healthy competition is permitted. In the contract carriers, long-distance movers, and so on, there is also permitted a certain amount of healthy competition and healthy overlap. Certainly there must be and there will be an overlapping, the result of which gives a person freedom of choice, and places people in direct competition in the same line of service within the same geographical area.

To this extent I think we will obtain beneficial results and give the choice that has always seemed to be so dear to people, but a choice that could of course make a shambles of any planning system.

QUESTION: As I understand the public utility concept, this does not prevent the consumer from leaving his area and seeking care in an adjacent area or a couple of adjacent areas, whatever distances he is willing to travel and able to travel. This might be a hindrance in Montana; you just don't go that far. In a metropolitan area it is now stated that many patients go past five hospitals to get to the one they want to go to. I don't see that the public utility concept changes that. Am I correct or am I wrong?

MR. HEDGEPEETH: I would say, with one exception, if the Ullman bill or parallel were adopted, and you had major segments of the population that were committed to a particular health care corporation, they would be expected to utilize that corporation unless they were taken to a different geographical area or unless the particular corporation did not offer the service. The system, even in the health care corporation, say, should not be expected to put the Rochester Clinic out of business. People can travel for specialized requirements.

REMARK: I would think that aspect of public utility might be very questionable. We have in Wisconsin two HMOs that we have started within the last year, but there is considerable transit through the metropolitan one at North Point and Milwaukee, and there is considerable transit at the Marshfield Clinic. We expect the third one to be established in Milwaukee some time this summer, and there will be no question that people will go past the new third one to go over to the North Point one, because of where their residence is and because of their election



to obtain their service from this particular group practice that has been established.

It seems to me that concept, as long as there is a mobility of the person seeking service—you don't get quite so disturbed about the public utility concept.

MR. ANDERSON: I want to ask George Allen a question for information. He mentioned medical foundations being a threat to the hospitals. What do you mean by utilization?

MR. ALLEN: The purpose of the medical foundations, at least viewed in New York, is twofold. One is utilization review and the other is physician's fees. To allow such total control to the physicians themselves has got to be dangerous. That is what they are trying to do. Indeed, there is a bill in the Legislature now to try to allow lay administration on governing boards of such foundations, and the medical society is fighting it tooth and nail because they want it to be simon-pure.

Another aspect of these foundations, at least in New York again, is that the past President of the New York State Medical Society, George Miller, who is considered a rebel in the AMA, is setting up an institute which would gather all the medical information from all the medical foundations into one big data bank, and using it from there. Once you have the information and the fees and you are setting up the prepaid groups, and you can control admission policies of hospitals, and for the hospital community having no say in that, has got to be dangerous.

QUESTION: I have two questions for Mr. Allen. With the state regulatory commission as you alluded to, you said it would possibly be funded out of a pool by hospitals. My first question is, would this be a local, regional and national commission? Second, what role do you see the AHA playing in relation to this commission?

MR. ALLEN: Whether it is local or state, I think, is strictly a geographical consideration. In New York they would have to be local, because there are just too many hospitals and too much population. In a state like Nevada it perhaps could be at the State level.

I think the matter of how this commission is financed has its pros and cons, and I am kind of on the side of its being financed by those that it regulates; so you take it out of the political field. As a matter of fact, in talking to some

of our State senators about whether they would support such legislation, they look at it very politically and say, "If it is going to cost the State any money, no." We say, "No; it will come out of fees paid by those who are regulated."

That is a concept that I think applies to some public utilities, electrical, transportation, and so on, now. I don't view it as working on a national level at all. I think the highest maximum level will have to be the state.

What role do I see the AHA playing? I think it is strictly stimulation for at least experimentation and investigation into such, and they have done that in the Ullman bill. I think it took a great deal of courage for Mr. Hedgepeth and that committee and the public utility panel to release their report. The fact that they only got three responses to it leads me to the conclusion that as long as you are not talking about money, you won't have the interest of hospital administrators. If you talk about denying them money, you will get their interest.

One example comes to mind. We structured an institute in New York City on the matter of public utilities, with twelve registrants. We structured one on Phase II, and we had 202 registrants because of the matter of money. We will change the system as to where we put the money. I think that is one of the methods that the Public Utility Commission could use to move.

QUESTION: So you see the commission as being autonomous in each region?

MR. ALLEN: Not totally autonomous. Generally speaking, yes, except in a state where, say, the Medicaid program might be administered because it is a single state agency. Then you have to coordinate that to make sure they adequately reimburse through the public utility system. On a regional basis it has to work its way up to a state agency which could have greater autonomy than a region. As long as Medicare is on the national level, I suppose you have to have some kind of national ties, too.

MR. HEDGEPEETH: With regard to the lack of response, it may well indicate that the same report should have come out ten or twenty years earlier, and that may account for the fact that the field was ready for it.

QUESTION: To go back to reimbursement, I gather the Commissioner of Health in New York State has a pretty good handle on reimbursement rates. I am wondering if that control over reimbursement and expenses has been enough to change the State's attitude toward utilization review, and so on.

MR. ALLEN: The Commissioner will claim that his control of reimbursement, which is total, has ameliorated the rise in the cost. He cites in 1968 maybe 18 percent; in 1969, 19 percent; in 1970 it was 14 percent; in 1971, 12 percent, and now they are predicting 9 percent in 1972.

But that is not doing anything for the quality of care and the real access and distribution of care. You are not controlling cost, per se—you are controlling revenue. I don't think the per diem approach is an effective way to do it. I think there is a lot to be said about reimbursement based on utilization, somehow, some way. One of the concepts there is reimbursement on an episode of illness. If you take the PAS system you take a particular diagnosis, and if the particular stay for that diagnosis is five days, you multiply it by the per diem rate, and that is what the hospital gets.

They have not at all given up the approach for utilization, because it is a way of redistributing care and making it more effective. The control of rates is strictly a revenue control and not a quality control. They have not given it up. They are still as independent in utilization review as they were before they had control over reimbursement.

QUESTION: They are still as interested in utilization review as they were before they had control over reimbursement?

MR. ALLEN: Absolutely. This is not a written policy, but it is spoken often. They are also interested in bringing doctors back into the hospital where they belong in the first place. There are always these little approaches in the Department of Health to make the physician an employee of the hospital. If that doesn't raise some hackles! They are trying to do this through utilization review. They are indeed trying to even control physician reimbursement through utilization. It is very much in the forefront in many different ways.

MR. HEDCEPETH: I might mention another arena. Massachusetts has a hospital rate-setting commission. Last November they undertook to

adopt regulations giving the guidelines by which they would establish hospital charges or reimbursements. Among other things, they provided that any fee for a consultant in excess of \$1,000 per year would have to be approved by the rate-setting commission. Among others, any professional association dues in excess of \$500 per year would have to be approved by the state rate-setting commission.

Hospitals in that State have filed a declaratory judgment attacking the validity of the regulations. The case was originally set for trial on May 8 and had to be reset, but no doubt from that proceeding we will have some guidelines as to the legal constraints within which rate-setting commissions may operate.

REMARK: I would like to make a statement and ask for Tom's advice. In Pennsylvania we have tried to staff a commission which would have three councils, one on rate review, one on licensure. We have also established some health care policy guidelines. We have discussed this with the State officials who buy our package essentially and think our package is perhaps better than what the legislators want to do, except the Governor states he will oppose it because he doesn't want the Commission because it takes away from him his right given to him by the voters to be able to establish who in his cabinet or within his governmental department will do the kind of things that the commission would do. I wonder whether you have comments or suggestions for us in Pennsylvania.

CHAIRMAN MAY: Before you comment, I have a man back there literally climbing the wall. Before we incur damage to the room we had better call on him.

REMARK: I am somewhat horrified. That is the only word I can think of. Up until relatively recently we were assuming that the people not in the hospital industry somehow had the strange view that revenue controls were not quality controls, that somehow a hospital could deliver quality by making it out of air and water. Somehow I thought I heard you say, George, that the ability to control revenue was not the ability to control quality. If that is the case, I would like to have you tell me how in the devil we can deliver it without the money with which to buy it.

MR. ALLEN: You can't. This is not an instance crisis. The commissioner of health or the other

controlling agencies don't do it all at once. They cut you back piece by piece. It is an insidious thing. Hospitals first rate their endowments. Then they start hiding their vendors. They go from three to six to nine months. Then they run to the bank for loans to meet their payroll and other working capital instant requirements. Then they say, "We were going to add a service, but we won't add it now." Then they start looking at existing services that they have that are losers—maternity, obstetrics. Maybe they start closing that down. Maybe that's a good thing.

After they get through with all of these options and they have precluded them, they have to look at some of the essential patient services. The ones we are looking at now are ambulatory care where reimbursement is inadequate. They are cutting down their methadone programs and alcohol programs. It is an insidious but constant deterioration of services.

We claim that we have got to bring that to the public's attention now, before it is too late. But regrettably they accuse us of always crying wolf, and they say, "Show me a hospital or service that is closed," and we can't yet. It is an insidious thing, and I swear it is going to happen as these rates are turned tighter and tighter with each succeeding rate period.

REMARK: If you don't prevent it, the statement is that revenue controls aren't quality control. I am sure the minutes will reflect that at least twice this morning you said that is only a revenue control, not a quality control.

MR. ALLEN: A revenue control, not a cost control. It doesn't control costs; revenue only.

REMARK: Certainly it does. If I cut my wife's household revenue in half, I guarantee you I will cut her household costs in half.

MR. ALLEN: Not in the long run. Let me give you a telling example: The unions in particular in the city are very powerful. Leon Davis is a hospital household word. The Commissioner of Health does not change the rates of reimbursement when he comes to a labor agreement. It is going to cost the hospital more. It goes out and finds other ways to meet those costs. He can't get his revenue increased, so he does other things. As I said, he raises endowments; he looks at services that he can cut back on. He goes to the bank. He has to continue to meet the costs because he has to continue to provide the care. The cutting back of revenue is not

going to control those costs at all. The hospital is still going to incur them, and that is where we are going to come to the impasse.

QUESTION: It may be, George, that that is the fact that people show up for Phase II meetings and not for the others, because apparently you are so crisis-oriented that Phase II that affects them right now you can convince them it got out; but are you sure that public utility is of the same crisis? Do you think it is insidious, slow, not important today? You tell me this is not important right now because we will be able to raid the endowments and borrow from the bank—

MR. ALLEN: No. It is very serious and critical, and we have to do something about it now, before it is too late.

QUESTION: Are you doing something?

MR. ALLEN: No, we are not.

REMARK: I am not convinced that arguing for the end result, the public utility approach, is the way to go in against people who are legislating for medical foundations for licensure. I know what the end result of that kind of negotiation is.

MR. ALLEN: You catch me in a confession. We are not doing anything significant to stop it, other than yelling.

CHAIRMAN MAY: I think it is clear that rate controls and quality controls and cost controls do interrelate, and you control one and therefore incur the consequences with respect to the others. It certainly is a dimension of the answer.

QUESTION: How do you get the state government to accept the commission idea, where you can have an independent group of people paid by the hospitals, having advisory councils on rate, franchises, and so on, to accept the commission, because the governor feels that he does not want to be controlled?

MR. ALLEN: I can only give you a political answer. It is the one we would try now. First, we would try to explain it is going to save him money in his state budget. The second thing

is that the controls he has now simply aren't working, because we have a crisis. The only way I think we are going to get legislation through for any kind of public utility commission is to create a crisis. That is the only thing that seems to persuade them. I am not convinced we can get one through in New York, because of this exact thing. We would be denying the Governor of power in a member of his own cabinet. I don't know what kind of advice to give you on it, sir, other than create a crisis.

MR. ANDERSON: What is a crisis?

MR. ALLEN: If every hospital cancels Blue Cross contracts because reimbursement is inadequate, that will create a crisis.

REMARK: It seems to me maybe the crisis is a crisis in leadership in health care. Toward the end of our discussions my suggestion would be, let us find out who is best in that field, the hospital or the physician or the department of health in a local situation or state. The AMA does say that relationship between the physician and patient is the most important and crucial thing in health care. Whether the hospital is most important, rather than pay a professional and others, they are demanding there an approach in relationship to the institution and not to the physician. Let us decide who is the leader, whether it is the hospital as an institution, or the physician has to maintain his supremacy.

CHAIRMAN MAY: I think our problem is to find somebody smart enough to designate the leader.

REMARK: It seems to me there is an analogy between where you stand in New York—and I am a New Jersey man who sits on the review committee for Blue Cross, and I am appalled at what I see. There must be an analogy between this kind of rate setting now and what is happening, and the differences that have happened across the country in terms of the public utility commissions and the electric utilities. Some electric utilities apparently have provided very well, and have had no problems at all. With other utilities, like New York Edison, brownout after brownout, and all we can expect is a continuation of brownouts.

Where does the responsibility lie? Just

because New York Edison didn't push hard enough, or because the Public Utility Commission wasn't properly oriented in terms of not just holding back but in trying to see to it that there was also proper care in terms of electric power? Where does the responsibility lie? Some electric utilities have done a good job, and others have done a lousy job.

MR. HEDGEPEETH: We must remember that the commission is not a substitute for management. I am not acquainted with the New York Edison problems, and I don't know exactly what contributed to them. I understand they have a little trouble with the telephone service in New York, too. Surely no one would expect a public utility commission to usurp management responsibility. They are perhaps to save them from affirmative errors, but each regulated industry must maintain its own initiative and its own resourcefulness, and so on. The fact that it is regulated is not going to be a good substitute for good management.

REMARK: There you are. I don't think we have got it. I don't see it when I look at those people arguing with Blue Cross over there. It is an interesting position to be in, not to be really directly involved, and to watch it. It is a one-way street.

CHAIRMAN MAY: I think the issues that have been raised in the last hour, and some of those earlier, are really crucial. I don't get a clear picture, as a result of what we have been talking about, of whether we really know what we want the controls to accomplish. I don't get a clear picture that we really know who we want to operate the control mechanisms. I don't get a clear picture that we really know what form the control mechanisms should take.

I have a hobby of collecting words, and a word I ran across a while ago is "nihilhillipillification." I won't write in on the board, but it refers to the process of rejecting everything suggested for good, logical, sound reasons, and never proposing anything to take its place. I believe there is a certain amount of that going on. I don't know whether I like the idea of the regulatees being the regulators. I don't know if I like the idea of a vacuum forming that we are all going to move into, nor do I know whether I like the idea of somebody laying on us things we can't live with or which will have untoward effects. I think we are really at an important point in

the development of what is going on, and we all seriously have to think about it.

It occurs to me we had better know what the total picture will look like when it is finished, and we had better have all the facts before we decide whether we are happy or sad. We are in the position of a group of oarsmen sitting in the bottom of a wooden galley ship, chained to their oars. The leader came in and beat on the drum to get their attention. He said, "I have some good news for you and some bad news.

*IMPLICATIONS FOR HOSPITALS OF CURRENTLY PROPOSED  
HEALTH INSURANCE LEGISLATION—PANEL DISCUSSION*

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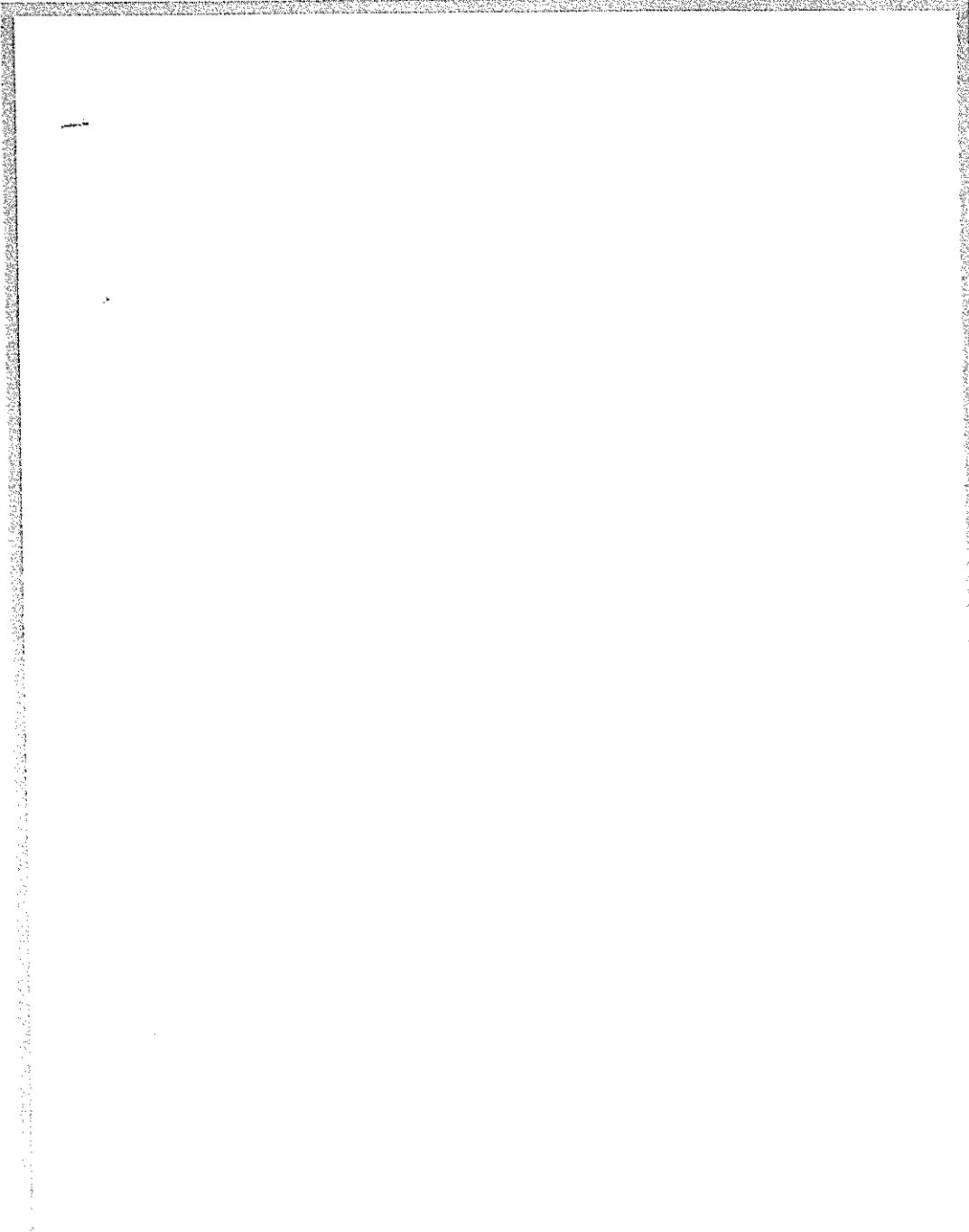
The good news is that Caesar has chosen our ship to tour the Aegean. Now the bad news: He likes to water ski." I have a feeling that is about where we are with respect to controls.

I have gotten a great deal out of the last day and a half, and I have enjoyed it. I think your participation has been absolutely remarkable. Thank you very much.

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