

Survival in Utopia (Growth Without Expansion)

*Proceedings of the Eighteenth Annual Symposium on Hospital Affairs
April 1976*

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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Table of Contents

1 INTRODUCTION

Session Chairman:
LAD F. GRAPSKI, *President*
Allegheny Hospital
Pittsburgh, Pennsylvania

1 INTRODUCTORY REMARKS

LAD F. GRAPSKI

3 A DECADE OF GOOD INTENTIONS

ODIN W. ANDERSON, PH.D., *Professor and Director*
Center for Health Administration Studies
University of Chicago

10 STRAWS IN A WIND OF CHANGE

DAVID M. KINZER, *President*
Massachusetts Hospital Association

18 THE NEW YORK EXPERIENCE—UTOPIA IN SHAMBLES

IRVIN G. WILMOT, *Executive Vice-President*
New York University Medical Center

22 DISCUSSION

22 MOBILIZATION FOR SURVIVAL

Session Chairman:
RON SPAETH
Vice President for Administrative Services, Evanston Hospital,
Evanston, Illinois

28 I. INTERHOSPITAL ALLIANCES

JOHN M. DANIELSON, *Executive Director*
Capital Area Health Consortium, Newington, Connecticut

36 II. INTRAHOSPITAL APPROACHES

a. SAMUEL J. TIBBITTS, *President*
Lutheran Hospital Society of Southern California
Los Angeles, California

40 b. GERALD W. MUNGERSON, *Executive Director*
Illinois Masonic Medical Center, Chicago, Illinois

43 DISCUSSION

43 STRATEGIES FOR SURVIVAL

Session Chairman:

RICHARD WITTRUP, *Executive Vice President*
Affiliated Hospital Center, Boston, Massachusetts

52 PANEL DISCUSSION

Reactor Panel:

- 52 H. ROBERT CATHCART, *President*
Pennsylvania Hospital, Philadelphia, Pennsylvania
- 54 STANLEY A. FERGUSON, *Consultant*
University Hospitals, Cleveland, Ohio
- 56 WILLIAM R. FIFER, M.D., *Director*
Regional Medical Education Center, VA Hospitals
Minneapolis, Minnesota
- 59 DONALD M. KILOURIE, *President*
Hospital Shared Services, Schaumburg, Illinois
- 62 ALAN B. MILLER, *President*
American Medicorp, Inc., Bala Cynwyd, Pennsylvania
- 64 JOHN E. PETERSON, *Executive Vice President and Director*
The Valley Hospital, Ridgewood, New Jersey
- 66 GAIL L. WARDEN, *Executive Vice President*
Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois

68 DISCUSSION

75 LIST OF PARTICIPANTS

Introductory Remarks

LAD F. GRAPSKI

CHAIRMAN LAD F. GRAPSKI: Good morning and welcome to the Eighteenth Annual Symposium on Hospital Affairs.

Over the years, it has been the practice to use three criteria to select the topics for the Annual Symposium.

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

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

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

Even though a committee brought this program together, it is my judgment that this year's topic certainly meets all of these criteria. The symposium this year was planned by a group, which I had the privilege of chairing. In addition, if you wish to complain about it, please see my friends, Milo Anderson, Dick Wittrup, Ron Spaeth, Dan Ford and Dick Gustafson.

We met here in Chicago last December to discuss the topics and speakers for this year's session.

I want to thank all of the committee members for their contributions. The attendance this morning is some evidence that perhaps we hit the mark very well.

Our title is: "Survival in Utopia (Growth Without Expansion)." The question we want to raise is: What can a hospital do to insure its survival and viability as an organization when funds for growth, expansion, or innovation are either cut off or severely rationed, when governmental agencies severely constrain the options and alternatives that are available to us, the public pressures us to reduce cost almost regardless of the effect that the reductions have on the programs that we have or the quality of the programs, while at the same time society holds the utopian view of equal access for all citizens to quality health care?

The late Sixties and early Seventies were extraordinary years for hospitals. While federal support for construction was growing, the Medicaid and Medicare programs and a developing concern for equal rights and equal access extended federal assistance and monies into new areas including both inpatient care and outpatient care, research and facilities construction. The expectation of an ever-

The Eighteenth Annual Symposium on Hospital Affairs conducted by the Graduate Program in Hospital Administration of the Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on the University of Chicago's campus on April 23-24, 1976. These symposia are a reflection of the strong concern of the Graduate Program in Hospital Administration with complex current issues in health care management.

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

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

expanding federal commitment to the development of new programs and facilities and to hospital growth developed.

Between '65 and '75 federal expenditures for care, manpower development, research and construction increased from \$20.5 billion to nearly \$35 billion, an increase of more than 70 percent. Simultaneously, the health care industry as a whole grew from 5.9 percent of the gross national product to just short of 8 percent of the gross national product.

During this ten-year period, successful administrators were those who dreamt big dreams for their institutions, had the confidence to take chances, and had the salesmanship to garner financial support from government, from foundations, from private donors, to expand their programs and their institutions. If successful, they were frequently permitted substantial authority and power and management. Aggressive leadership, vision and venturesomeness were the cardinal virtues of the manager.

Abruptly this climate has changed. Since 1972, 29 states have adopted Certificate-of-Need laws. In the last two years, 17 states have established rate review commissions. The Social Security amendments of 1972 constrained behavior financially through surveillance of quality programs such as the PSROs and through the establishment of Section 1122 organizations.

Public Law 93-641, the Health Planning and Resource Development Act, has been termed by many as the Federal Certificate-of-Need Law. It ties eligibility for federal funds in local areas to the require-

ment that the individual institution conform to the plans made by the private or public planning group in the area.

Our autonomy has been greatly reduced. Our freedom of action has been severely curtailed. Our organizational prerogatives have been constrained. Much of the health and strength of our institutions has been conditioned by our ability to continue to develop new programs, to innovate, to expand facilities and services; in short, to grow. This appears to be no longer possible.

Our task at this symposium is to explore these issues and to attempt to develop strategies to insure the survival of our organizations in the face of them.

This symposium is divided into three sessions. The first, this morning, will review the decade of good intentions, look at some of the regulatory activities that are taking place and where they might lead and review a case study, that of the City of New York, which has many lessons for all of us.

This afternoon, the second general session, we will look at both the inter- and intrahospital approaches to the issues as to how do we mobilize for survival, and finally tomorrow morning we will hear from seven knowledgeable individuals who have on their own evolved strategies for survival which they are applying in their own settings.

Our task there will be to evaluate and explore the applicability of their approaches to our needs. The program is so arranged to provide ample opportunity for audience participation and discussion, and I very heartily encourage it.

A Decade of Good Intentions

ODIN W. ANDERSON

CHAIRMAN GRAPSKI: Odin Anderson hardly needs an introduction to this group. As the Director of the Center for Health Administration Studies and a faculty member in the program of Hospital Administration, we have had the privilege of hearing from Odin many times before. He tells me that he has seldom worked as hard or enjoyed the writing of a speech as much as he did this one. His title is: "A Decade of Good Intentions," and the speaker is most qualified to discuss it. Odin Anderson!

DR. ODIN W. ANDERSON: Thank you very much, Lad.

It is always a pleasure to participate in the Annual Symposium and meet old friends and colleagues and share our common tribulations such as they may be and look toward the future.

Today the National Health Planning and Resources Development Act of 1974 is a very clear example of the close relationship between a particular political system and the problem solving style generated by that system. This Act could not have taken place, or in the form it did, in any other country. The Act tries to interlock the various levels of government and the many interest groups into a fairly loose framework for internal bargaining.

I will try to clarify what you undoubtedly know in your bones—the political and health service context in which you operate—but do not take the time possibly to raise the level of your consciousness as a negotiator and bargainer. I presume to be a neutral observer, but given my audience to the degree I stray from neutrality, I will be neutral on your side.

WHERE WE ARE NOW

Until a few years ago, it was the common and valid assumption that our health services delivery system was dominated and shaped by the providers, presumably to the advantage of the providers. Be that as it may, also until recently, both the govern-

ment as buyer and the public as patients and buyers increasingly sought and bought services from this delivery system. We have experienced a euphoria of expansion by relatively open-ended reimbursement methods.

This, of course, is changing. The providers very success as a leading growth industry is now resulting in government and consumer interventions of various sorts to contain costs. We have shifted from a simple relationship between providers and buyers to a complicated arena of the major interest groups—government among them—to an arena with an emerging complex of rules in order to give the consumer and government more influence over the providers and the organization of the delivery system.

Still, the Act at an early point in the text makes this charge to the providers: "Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels."

So, take this particular section literally and seriously.

In interpreting the Act, it is evident that the frying pan is at the local level in the Health Service Areas and the Health Service Agencies. It is on the Governing Board that groups at interest will be eyeball to eyeball in accommodations and compromises.

The specific body where you will be sending your voting representatives presumably fully instructed is the governing board.

I will not go into details on the many provisions of the Act, but will point to the pivotal aspects which affect you directly, where you can have the greatest influence and where you will be under the greatest pressures as providers.

There are two advisory boards above you; one on the national level and the other on the state level. The board on the national level is advisory

to the Secretary of HEW and the board on the state level is advisory to the governor.

The national advisory body called the National Council on Health Planning and Development, is entrusted with setting guidelines for health planning on a national level.

You may recall your own professional association, the American College of Hospital Administrators, in essence recommended the creation of a national planning body in the publication of the Special Study Commission on National Health Insurance.

The report reads: "Recommend the creation of a national planning body lodged in the highest level of the governmental structure and committed to continuous and comprehensive planning (in 1974)." This was the very year that the National Planning Act was passed.

"The function of such a body should be to provide information and advice pertinent to the exercise of the decision-making prerogatives of Congress and the Executive Office. The strategic planning mission should be the development of a long-range perspective on the nation's health goals, the definition of meaningful objectives in concrete and quantifiable form, and the identification and assessment of alternative approaches to their fulfillment."

(Remember, this is from your own professional association.)

Already in the Act there are ten priorities set by Congress for the National Council to follow and which presumably you are also to follow on the local level. Abbreviated, these priorities are hardly new any more; they have become the conventional wisdom of proper priorities, like emphasis on:

1. Primary care services.
2. The development of multi-institutional systems for coordination and consolidation.
3. The development of medical group practices,
4. The training and increased use of physician assistants,
5. The development of multi-institutional arrangements for the sharing of support services,
6. Promoting of activities leading to improved quality such as PSRO,
7. The development by health service institutions of the capacity to provide various levels of care on a geographically integrated basis,
8. The promotion of activities for the prevention of diseases,

9. (And this I quote fully) "The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health services institutions," which of course, will affect you most directly.

And last, and certainly most difficult, and I wonder if it is even desirable sometimes,

10. The development of methods to change lifestyles (namely, I suppose, to remove cigarette vending machines from your hospitals and serve banana cream pie only once a week).

I return to the governing body of the Health Services Agencies, the administrative bodies in the health services areas.

Contrary to the recommendations of the College and to precedents in the hospital planning councils, this governing body, is both a planning and administrative body. The College prefers that the planning be enforced on the state level rather than from HEW to the local level.

Planning on the local level should be divorced from enforcement and implementation. The governing body, however, has the power to enforce the plans formulated by it by majority vote. It is on this body that the consumers are hoped to have their major influence since they are in the majority (a majority, but not more than 60 percent of the members).

The Health Service Areas concept, however, is in agreement with the recommendations of the College to establish regional areas with known populations in which the total range of services can be planned in relation to the determined needs of their population. The Act joins planning, administration, and enforcement at the Health Services Area level. This will be your primary day-to-day arena in planning for the health services of the area in deliberation with the members of the governing board, the majority of whom are consumers.

Who is the consumer? The Act reads: (paraphrased) "A majority but not more than 60 percent of the members, shall be residents of the Health Service Area served by the Health Service Agency who are consumers of health care and who are broadly representative of the social, economic, linguistic and racial populations and geographic areas of the Health Service Area and major purchasers of

health care." This last I assume are employer and employee groups. "The remainder of the members shall be residents of the Health Service Area served by the agency who are providers of health care. They represent (a) physicians (emphasis on practicing physicians), dentists, nurses and other health professions, (b) health care institutions (emphasis on hospitals, long-term care facilities, and health maintenance organizations, presumably medical prepayment plans which provide service), health care insurers, health professional schools, and allied health professions. (Not less than a third of the providers of health care shall be direct providers.) In addition, members can also include publicly elected officials and representatives of public and private agencies concerned with health."

Given the ten guidelines, it is apparent that hospital care is to be de-emphasized in favor of more out-of-hospital types of services, and you are asked to participate in your own gradual demise.

Paraphrasing Churchill when he became Prime Minister during World War II, those of you who will be appointed to membership on the governing bodies of Health Service Agencies will likely say, "I did not become a member of the governing body to officiate at the weakening of the hospital system," i.e., if you take your charge seriously in the context of interest groups as revealed in the composition of the governing bodies. This is what I mean by neutral on your side.

Your professional association, expectedly, makes the pronouncement: "The health services delivery system is anchored in the health care institutions serving local communities. At this level responsible decision-making is crucial. Legally and in the mind of the public, hospitals are focal points of corporate responsibility for the provision of services. It is incumbent on these organizations to ensure that the process of governance reflects community needs and interests and maintains the fiscal accountability of the governing body, the institutional management, and the medical staff, severally and jointly."

It would seem then that the maintenance of a strong hospital base is necessary to carry out the priorities listed by Congress in the Act. It is the primary springboard for corporate and large scale action in the health field.

HOW WE GOT THERE

At this point, I will leave you on the brink of

your near future and return to it later and retrace in very broad strokes the stages of development in the early rudiments of health planning in this country up to P.L. 93-641. I believe this is necessary to assess the momentum of events toward a structuring of the health services system. We continue to be much a product of incremental change. Even the current Act illustrates this in that there are no mandatory objectives only a mandatory process to attain a few agreed on priorities among many objectives as the various interest groups spar with each other.

This, I think, is the essence of the governing board and the health service area level.

I recall asking the late Dr. Edwin Crosby what bargaining power he had with the federal government. This was during the Medicare debate. He answered, "Seven thousand hospitals."

Most of these hospitals are community-type hospitals with a network of interrelationships with the community power structures. The community-type voluntary hospitals continue to be the backbone of the hospital delivery system with the privately practicing physician. The dominance of the voluntary hospital and the private physician has a long history unique to this country.

By 1920 or so the main outlines and characteristics of this essentially private delivery system were clear. Since then, this system has encountered third party payers, and increasing regulations as costs have increased. Now the extreme plurality of this system is being questioned. There is a trend toward reducing the number of decision-making points through reimbursement methods and sources of funds and regulation of rates and supply. Each hospital is thus finding its discretionary decision-making area increasingly restricted so as to become more related to other hospitals in the system than previously. This is presumed to make for a better overall system.

At this point you are asked to give, but not to take. The first attempt at an overall systems approach in the supply of beds was the Hospital Survey and Construction Act of 1946 (better known as Hill-Burton). At the time, I do not believe it was regarded strictly as a planning mechanism. The Act was a recognition by Congress that the voluntary hospitals were not getting the capital they once were

for renovation, expansion, and hospital facilities in rural areas.

This Act had a multiplier effect on hospital expansion in this country by providing substantial startup costs, the bulk of the remainder being raised locally. The planning aspect of the Act was the states having to make a complete inventory of their hospital facilities in order to obtain a rough idea of access. The rural political interests were influential and successful. The support of the Congress for the voluntary hospital was apparent and a "given."

This Act gave the voluntary hospital a great boost for capital funds together with the burgeoning voluntary health insurance for operating funds. There was a general policy of improvement and expansion. The result was one of the finest hospital physical plants in the world.

The second landmark in the history of health planning in this country was the publication in 1961 of the report of the Joint Committee of the American Hospital Association and the U.S. Public Health Service entitled: *Areawide Planning for Hospitals and Related Health Facilities*. This report was a culmination of several years of discussion between the private and public sectors as represented by the American Hospital Association and the U.S. Public Health Service. The objective was to establish planning as "an influential, ongoing process, particularly in metropolitan areas."

After this document was published, the voluntary planning movement grew rapidly. Federal money became available to support voluntary health planning agencies around the country. Within a decade in the Sixties the number of planning agencies increased from nine to eighty. At least the minimum result of the voluntary planning agencies was that of compiling a great deal of information on local community characteristics and inventories of health services supply and expenditures. It was hoped that this information would help devise a more rational health system among reasonable people in the community power structure. There was a shift from purely physical aspects of the construction of hospitals embodied in the Hospital Survey and Construction Act of 1946 to the valid concern with the relationship of hospitals to each other and to other types of health services.

Mild as these planning efforts appear, they do illustrate the profound dislike for directed planning from a central governmental body in this country.

No other country has tried voluntary, i.e., unofficial planning. In other western democratic countries, it does not seem reasonable that health planning should be in the voluntary or private sector with the government as a partner, not to mention the government paying the planning bill as well. Planning is a public sector concern with direct public accountability. Obviously, this is so, in part, because other countries never developed the private sector health care infrastructure to the same extent as did this country. They had no parallel in a Dr. Crosby who said that he could negotiate (at least in his time) from a power base of seven thousand hospitals!

Even after eighty or so hospital planning councils were established, there was no clear evidence that the bed supply was more rationally determined than in unplanned areas, that costs were rising less rapidly, or that there was less duplication of facilities—the cobalt bomb being the favorite target. Obviously, planning councils were being subjected to very powerful economic and medical technological forces over which they could not be expected to have control.

So, inevitably, government (the ultimate source of social control in society) enters more deeply into the arena and hopefully is to brood over the larger public interest more equitably than the disparate parties in the private sector. Still, the public sector needs countervailing private power also. Beseeching individual members of Congress is not enough. Private sector coalitions emerge—witness the National Coalition for Health Funding composed of voluntary health agencies and organizational friends of these agencies. The American Medical Association and the American Hospital Association are not members of this coalition, but I understand there is liaison on mutually appropriate issues.

The vehicle for more government action in health planning took the form of the third major landmark, the passage by Congress of the Regional Medical Program for Health, Disease, Cancer, and Stroke in 1965 and the Comprehensive Health Planning and Public Health Service Amendments of 1966. The Regional Medical Program tried to get medical schools and practitioners together on specific diseases. The Planning Act provided for comprehensive planning for health services, manpower, and facilities on the state and local levels. This Act was originally enacted for two years—this short dura-

tion in itself symbolic of our reluctance to engage in long-range planning. Both Acts are now superseded by the legislation of concern in this symposium.

WHERE ARE WE GOING?

The future is still with us in the present Planning Act. The evolution from the loosely and generously conceived Hospital Survey and Construction Act of 1946, to the more detailed report of the Joint Committee of the American Hospital Association and the U.S. Public Health Service in 1961, leading to the proliferation of hospital planning councils, and then to the Regional Medical Program of 1965 and the Comprehensive Health Planning Act of 1966, to give government more influence in planning to the present planning act illustrate changes through incrementalism.

Concurrently both the government and the private sector continued to pay providers more or less on demand through Medicare, Medicaid, and voluntary health insurance. Health services became officially regarded as a right. Inevitably a generous public policy such as this will experience a crunch, and this was the period of the Johnsonian euphoria when everything seemed to be possible and when we declared war on everything including poverty.

Again very briefly what is the foreign experience with planning?

There is a glib assumption that other countries are ahead of the United States in health services planning and that they have a body of knowledge and experience from which we can learn and apply here. This is not true. Rather, other countries are facing the same cost and distribution problems that we are under their governmental systems and simultaneously turning to planning as the primary means to allocate health resources. The planning is just as new in Europe and in Canada as it is here.

A health planning technology and methodology is still in formation. Other countries have not had any more time than have we in testing the planning methodology. All the countries are groping for proper norms of adequate beds, personnel, and politically tolerable costs. Other countries are ahead of us in mitigating the burden of high cost episodes on families, the original intent of health insurance, public or private. We share all other problems of running a health services system.

The same situation is true in developed coun-

tries with centralized political authority and economic planning systems in Eastern Europe and the U.S.S.R. They do not have validated norms either. Rather, they establish rule-of-thumb norms of adequacy under a tightly controlled administrative and financial structure, in the U.S.S.R. case a very generously funded system.

The actors within these structures have a rather clear idea of the boundaries of the system, the catchment areas, the physicians and the hospitals to which they are assigned, and the global budget during a fiscal period. There is nothing subtle or mysterious about this method. Western countries are also beginning to adopt this method in various degrees of arbitrariness because in all countries we have not yet found a more acceptable way to control the system. All countries including the United States are moving toward various degrees of arbitrary structure and unvalidated arbitrary norms. The marketplace of choice and decision becomes exclusively a political one.

My conclusion after investigating the operation and data of a wide range of health services in developed countries is that there is no relationship between the ownership of facilities, methods of paying physicians, sources of funding or organizational structures and the amount of money a particular country spends on health services. My interpretation from this conclusion is that the amount of money a country is willing to spend for health services is a purely political decision emerging from whatever decision-making matrix, private and public, a country may have.

I grant that it is easier—the body politic willing—to control a highly structured and planned system than a multi-nucleated decision-making system still true of the United States. What I wish to stress is that there is no inherent reason why a highly structured and planned system is any cheaper or even more equitable than a loosely structured system. Well thought out public policy appears to be difficult to implement in any system, the health services are so complex in its many ramifications as to demand, supply, and funding. The U.S.S.R. has shown that a generally conceived system can be implemented given the public policy and the mechanisms to carry it out. As an example, when I saw

the pyramids in Egypt last summer I said, "Well, this is what you get when you have a public policy, which was implemented." It probably consumed one-half the gross national product.

The United Kingdom has shown that a tightly controlled system as to supply and funding can also be carried out given the public policy and its general acceptance.

If it makes little difference what may be the type of organization, ownership of facilities and sources of funds and the amount spent for health services, where does this leave you in the National Health Planning and Resources Development Act? I left you at the brink of your near future in the introduction of this talk; let us now speculate on your operating strategies on how to work with this Act. And I am anticipating a lot will be said today and tomorrow.

All interest groups are exhorted to have the public interest at heart rather than the individual self-interest. The Planning Act, as I said before, is trying to infuse a heavy consumer influence interest in the decision-making in resource allocation and mix of objectives beyond the usual direct appeal to legislators. The major arena will be the Health Services Areas and the Health Service Agencies under guidelines from H.E.W. Still, the consumer is no monolithic entity. Given the specifications for the composition of consumers there is little assurance that, at least initially, the consumers will speak with a concerted voice in bargaining with the providers. You will recall, there are linguistic, ethnic, and racial specifications. The consumers' voice may be fragmented against the likely more unified voice of the providers.

Consumers, as specified, can become as self-interested for their particular constituents, as the providers are accused of being. Still, beware of the "nonpartisan partisan" who claims to speak for the public interest more than others. As stated by Lindblom in his book: *The Intelligence of Democracy*: "The avowed partisan is often a more conciliatory adjuster than the covert partisan who thinks of himself as responsible for the public interest." You know where the avowed partisan stands enabling more self-conscious trade-offs.

In regard to choice of operating strategies, I wish to share with you three models of large scale decision-making in political systems relating to the formulation and implementation of the planning act

in which you will be involved as an interest group.

These models were formulated by Allison in his book: *Essence of Decision: Explaining the Cuban Missile Crisis*. It shows you how widely you can range as to models of action. He studied the Cuban missile crisis and the stages of decision-making and the actors in it and he came out with these models applicable here. There may be confrontation in the implementation of the Planning Act, like there was in the Cuban missile crisis, but I would imagine not as lethal.

His three models are labeled (1) The Rational Actor, (2) The Organizational Process, and (3) Governmental Politics.

The concepts and tools of the rational actor model are the building of elaborate and elegant models of systems with operations research, input and output measures, feed-back loops, and specifically defined objectives. The assumption is that all we lack is proper information. It is assumed that there is a deep and narrow consensus on objectives and levels of attainment. All actors are rational, including the patient who will not ask for unnecessary services. I believe most of us carry this model around in our heads as the ideal. In short, in doing so, we run into models two and three in real life which according to industrial engineer-types and systems analysts are an aberration because they encounter nuisances like people, bureaucracies, and politics. I believe we are gradually seeing model one as naive, a holy grail, or maybe not as holy. We reconcile ourselves to trying to understand and work with bureaucratic behavior, still keeping model one in mind as an ideal assuming that all people are rational.

Let us turn to model two, which is concerned with behavior of large organizations, private or public. We are gradually disabusing ourselves of the false notion that large organizations operate according to model one as rational and predictable entities which carry out a series of decisions in an orderly manner. Paraphrasing Allison, large organizations consist of a conglomerate of semi-feudal, loosely allied organizations, each with a substantial life of its own such as H.E.W., large medical complexes and Harvard University or for that matter, any large state university. According to Allison, then: "Governmental behavior can therefore be understood according to a second conceptual model, less as deliberate choices and more as *outputs* or

large organizations functioning according to standard patterns of behavior.”

Continuing the quotation: “To be responsive to a wide spectrum of problems, governments consist of large organizations, among which primary responsibility for particular tasks is divided. Each organization attends to a special set of problems and acts in quasi-independence on these problems. (You in the hospital field know the dozen or more regulatory problems that you encounter.)

Thus, government behavior relevant to any important problem reflects the independent output of several organizations, partially coordinated by government leaders. Government leaders can substantially disturb, but not substantially control, the behavior of these organizations.”

The Planning Act, is, of course, firmly embedded in the H.E.W. matrix and the state and local political levels. You will have many influences to watch out for, and they will not add up to model one. I would assume you are fully acquainted with model two, which I just described, but perhaps you need to understand its labyrinthine quality more. It does have a logic of its own which skill and patience might unravel. Your tactics and objectives are to be bureaucracy busters, finding loopholes here and there short of engaging in litigations or breaking laws.

Now let us move to model three, another level of action, in fact, the overall context on which models one and two operate, and interpenetrate them.

The leaders who sit on top of organizations are not a monolithic group. Rather, each individual is a player in a competitive game. The name of this game is politics in the large sense of the word. Government behavior can thus be understood according to this third model as results of this bargaining game. Unlike more or less unitary action of a government agency in model two, model three sees many actors as players, players who focus not on a

single strategic issue but on many issues as well within the larger problem such as national health insurance and national health planning. These players do not act in terms of a consistent set of strategic objectives but rather according to various conceptions of national, constituent, and personal goals, “players who make government decisions not by a single, rational choice, but by the pulling and hauling, that is politics.”

In the National Resources Planning Act people will share power particularly on the HSA level, and, of course, Congress’ power of appropriation. The process is essentially political in the profound sense of the word, and not meant pejoratively. The process is, in fact, a necessity. No one group is capable of, nor should be entrusted with, the formulation of a health service delivery and financing system. In this process sometimes one group committed to a course of action triumphs over other groups fighting for other alternatives.

In any case, what moves the chess pieces is not simply the presumably logical reasons that support a course of action, but the power and skill of proponents and opponents of the action in question. This would seem to be the type of arena which the Planning Act is trying to construct. You as administrators are challenged to function in this arena as an advocate of your institution in relation to other interests in a manner which you have not had to face in the past, at least at the same intensity.

There can obviously be no manual to guide you, but there are models of the art of successful politics all around you, even in the hospital field. You need to operate first as a politician in the large sense of the word for your institution and second as administrator.

I wish you good luck!

Straws in a Wind of Change

DAVID M. KINZER

CHAIRMAN GRAPSKI: Our next speaker, Dave Kinzer, is the President of the Massachusetts Hospital Association. Massachusetts is perhaps more deeply involved than any other state in regulation, control and manipulation of the health care system. What we have asked Dave to discuss is where we are today in terms of structure and characteristics of the health care system, what is happening in the public arena with respect to the growing suspicion about the need for further growth of health care facilities and what the future holds for us in this arena.

It is a big order, Dave. I know you can handle it. Ladies and gentlemen, Dave Kinzer.

MR. DAVID M. KINZER: Thank you, Lad. The last time I followed Odin Anderson on a program was at the Duke Forum several years ago. The main difference was that this was the second day, Saturday morning, and Odin was next to last and I was last. I remember vividly what Odin said. He said, "Now that everything possible has been said on the subject, both relevant and irrelevant, you can now listen to Dave Kinzer."

This inspires me to rejoin, so let me say this. After listening very carefully to everything Odin had to say, it is clear to me, at least, that the program, the symposium, would be just as far advanced as if I was just starting it.

My job is to talk about "Straws in a Wind of Change," and I have 10 straws that I have identified. I will go through them as quickly as I can.

The first is that right now we are staring down the gun barrel on the reality of limited resources. We know that federally we are hearing now about the proposed \$1.1 billion cut in Medicare in the Senate and the \$300 million cut on Medicaid.

I must also relate the inflamed and predatory political environment in Massachusetts because we are up against the same thing. Our legislature late last year appropriated 410 million dollars for 510 million dollars' worth of care under Medicaid. They

instituted a number of cuts that haven't yet worked.

In this environment the Governor came out as his number one priority with a proposal to control hospital costs. In the process he cut out medical services for the whole general relief caseload and blamed us. This is 25 million dollars' worth of care.

He put in a bill, House Bill 3160 which I won't describe, but it was an elaborate set of controls that, in effect, would have put one man at the console with a set of dials turning the different departments of hospitals on and off.

In this environment with the state going broke, we have been, to say the least, slightly on the defensive.

One of the tactics used by leaders of the Administration was in the context of the cuts to say that one of the reasons we have had to cut off hearing aids to old ladies is because we haven't controlled hospitals' costs.

They also cut out dentistry for the relief of pain and blamed it on the hospitals.

We have been in this hassle for over a year now, and as recently as Monday, I had two meetings, one with a senator who wants our support in restoring all these cuts and the other with a senator who is now committed, he told us Monday, to get some kind of cost control bill passed this year because it is an election year. It won't be what the Governor wants, but it will be something.

Where we are on this, in a state which has led the country, I think, in its generosity on entitlements, is at the point where there just isn't enough money to do it all, and I say with some sense of discouragement that there never will be again. This is happening federally.

The implication of this, of course, is that cost reimbursement is dead. We are going to have another system.

The second straw in the wind, and it leads clearly from my first point, is that there is no firm indication yet of political acceptance of the logical corollary of the reality of limited dollars which is limitations on services.

In spite of what the Governor has done, he has indicated publicly that he wants to restore all the benefits as soon as possible, that is, when he controls hospitals' costs.

I come from Massachusetts in the spirit of Senator Kennedy—a spirit that still has strong support—who believes that medical care is a right.

I can say to you—and there are some people here from Massachusetts—that this is one of the things he has done—in contrast to his stands on busing and birth control—that has made him popular and maintained his popularity.

I had some exposure fairly recently to the Democratic Primary, and got involved through a friend with advising Mo Udall on what he should say about health. There were eight Democratic candidates at that time, and they were competing on what they would say. I scratched my head a bit because I like Udall. What should I tell him that will get votes? I ended up saying, "Mo, you have got to be for everything: Comprehensive care, complete access, prevention, everything, because if you say anything else, you will lose votes," which is true, and he said that and every other candidate said exactly the same thing.

I met a couple of weeks ago with the Governor to have a friendly discussion on cost control, and one of the things I said was that, "I believe, Governor, you know how much money you have; I don't, and you have trouble here and I am sympathetic. But one thing you have to realize is that if you do what you want to do, we are going to have to cut services."

He got mad. He said, "I don't believe that. We are a rich country. We have in Massachusetts and around Boston the greatest resources for medical care in the world, and I just can't accept the fact that the 75-year-old ladies can't continue to get their hip replacements. What is wrong is that you have got to change the health care delivery system. I belong to the Harvard Community Health Plan, and I like it. It costs 30 bucks a month less," and he went on like that. And I decided I wasn't going to argue about prepaid group practice and all of that, but he reflected something that is very strong, not just in Massachusetts but everywhere. It is simply this—most politicians don't believe that they can't keep their promises, which have been made abundantly, about comprehensive care for all.

The third point, given the above, the game for

the next two or three years will be to squeeze the system. How much of a squeeze can be absorbed without really hurting the system on quality and access is now a prime question.

My own guess about this is that the system can be squeezed about 10 percent, adjusted for an inflationary impact, and I say this making three assumptions that may not be justified.

One is that some incentive can be put into the reimbursement system to save money, and on this subject I want to relate to an individual who has come to be called the "Sage of Boston." His name is Dick Wittrup. He is the only person involved in Massachusetts that can still afford to publicly tell the truth, and the reason he can is that he hasn't built his hospital yet.

These are two quotes from Wittrup. (1) "The only way hospitals can get income is to spend money." (2) "The only way to get hospitals to spend less money is to give them less money to spend."

There is great wisdom in this, even though it has made Wittrup less than popular among his colleagues. The real implication of this, is that we are going to have caps, one way or another. That is the way we are going in Massachusetts, and the caps are going to be on the income or expense some way or another. Then some things change on incentives. What has changed is the incentive not to go broke, a very clear and driving force.

And assuming this, and I do assume it, there are two other assumptions that may be justified. One is there will be a major move in the direction of consortia, consolidation, mergers. The second is there will be more effective internal efforts with medical staffs on being a little more selective on who gets expensive services.

On the first one, John Danielson will talk about the subject later. I just happen to feel, that it is really rather unrealistic to get consortia going when the individual components of a consortium have no incentive to reduce their costs. The system still encourages them to build their cost formula with more services and more activities and to force them together and say, "Do less," is pretty hard to do.

The second point is, up until now, and we all know this, there has been no motivation for administrators generally across the country to encourage their staffs to admit fewer patients and prescribe

less procedures. In fact, the motivation has been exactly the opposite.

The fourth straw in the wind: The controls now being imposed on our hospitals are now out of control, and from the administrative standpoint have reached the point of unmanageability.

A prime agenda item for our field must become the reform and rationalization of our control system.

I have put on the blackboard a listing of the controls that are now operational in Massachusetts, classified according to whether they are "cost provocative," "cost suppressive," and "cost preventive." Before I try to explain this, permit me one general comment. We have reached the point where the outpouring of the laws and regulations we are getting, both state and federal, has gone far beyond the capacity of the individual hospital to cope with it. Hospital administrators are throwing up their hands and crying uncle. I have a very clear picture of what is now happening. When the latest regulations land on the administrator's desk, he opens the front cover of the document, takes one look, and says, "Oh, God, who in my organization can I send it to this time?" So he sends it to the

fiscal office or the personnel office and they don't read it either. I know this, because questions about regulations which prove the questioner never read them always land with our state hospital association. This is another perverse reason why hospital associations are becoming indispensable, and also more expensive.

I must confess to you that the same thing is beginning to happen to me as the chief executive officer of a hospital association. They land on my desk, and I take one look and I say, "Oh, God, who shall I send it to this time?"

Because an explanation of the Massachusetts hospital control system would be a treatise in itself, I won't even attempt to explain how all these controls work, or don't work. I will just explain my classification system.

"*Cost Provocative*" controls are everything government has been doing to improve standards that increase our costs. Up until Medicaid-Medicare, it was all government was doing. I include, for obvious reasons, the Joint Commission on my list. Cost provocative controls had a head start on all of the

MASSACHUSETTS HOSPITAL CONTROL SYSTEM

"COST PROVOCATIVE"

1. Hospital Licensure
2. Health Manpower Licensure
3. Professional Education Accreditation (AMA, NLN)
4. JCAH (Including SSA "Validation Surveys")
5. Hill-Burton Hospital Construction Requirements
6. Life Safety Codes (Fire, Plumbing, Sanitation)
7. Third Party Mandated Benefits
8. Hill-Burton "Charity" Regs
9. Hill-Burton "Community Service" Regs
10. Minority Rights, Affirm. Action, etc.
11. Employee Rights (Taft-Hartley, Minimum Wage Unemp. Comp., Workmen's Comp., OSHA, etc.)
12. Patients Rights
13. Environmental Protection
14. Emergency Medical Services Regs
15. Community Mental Health
16. Cash Flow Controls (Medicaid)

"COST SUPPRESSIVE"

17. "Allowable Cost" Controls
18. Cost Related "Inclusive Rate" Controls (Medicaid)
19. Industrial Accident Rate Controls
20. Charge Controls
21. Ceiling Controls (Section 223)
22. Classification Controls (Section 233)
23. Medicaid Income Sanctions
24. Utilization Committee
25. Occupancy Controls
26. Medical Fee Controls
27. Blue Cross Contract Controls
28. Blue Cross Premium Controls
29. Patient disincentive controls (copay, deductibles, etc.)
30. Controls on special charges (patient records, etc.)
31. MAC (Maximum Allowable Cost drug reimbursement policy)
32. Malpractice Controls

"COST PREVENTIVE"

33. Growth and Development
34. PSRO
35. Specialized Service Controls (Dialysis etc.)
36. "Appropriateness" reviews (PL 93-641)
37. Benefit Controls

others and are much more firmly entrenched on the "system." They keep increasing the number. The latest on the Massachusetts scene is "patients' rights" legislation, which guarantees the employment of more ombudsmen and patient advocate-types in our hospitals. It also guarantees more income for lawyers. I put "cash flow controls" (#16) on my list because I don't know where else to put it. This represents what Massachusetts and many other states are doing when they run out of Medicaid appropriations. They solve their own cash flow problems by not paying hospitals. This sends our hospitals to the bank to borrow chunks of money to meet the payroll, and of course the interest costs, allowable under most reimbursement formulae, soon enough become another element in the pattern of inflation which our government leaders so loudly deplore.

Of the items on my "cost provocative" list, the most expensive have been: (1) Hospital licensure and manpower licensure in combination which have imposed rich and ridiculous staffing patterns on our hospitals; (2) The life safety codes and Hill-Burton construction standards which have escalated our physical plant costs; and (3) "Employee Rights" which have had enormous impacts in recent years that I don't even need to talk about.

"Cost Suppressive" controls are more recent in origin. Broadly, they are representative of contrivances by government to justify paying hospitals less than it costs them to render a service. The theory is that this will force the hospitals to spend less. A testimonial to the fact that this idea hasn't worked is the fact that Massachusetts, with more "cost suppressive" controls than any other state, has experienced more abrupt increases in our per patient day expenditures than any state I know. According to AHA data, between 1967 and 1974, our per patient day expenditures, acute hospitals only, went up 162 percent. Over the same time span, the average increase nationally was 137 percent. For all of the states in New England except for Massachusetts, the average was 135 percent.

Under my "cost suppressive" heading we have no less than six separate systems on the reimbursement end operating in parallel. Here is a somewhat facetious description of how these six systems can be distinguished, one from the other. Medicare decides what hospital costs are "reasonable," Medic-

aid decides how much below "reasonable" costs they can get away with paying, the Section 223 "routine costs" ceilings decide when "reasonable" is just too much, the industrial accident rate controls decides a rate that industry can afford to pay, the Blue Cross contract control decides how much our plan should be allowed to pay hospitals while assuring that the Plan can stay solvent and our new charge control system now decides how much over costs hospitals should be allowed to charge non-governmental and non-Blue Cross patients so that the hospitals can stay solvent.

"Cost Preventive" controls are the newest thing, the ones that are supposed to prevent expenditures or commitments. They therefore tend to be the least painful of my three categories. Certificate-of-Need clearly falls under this heading. The hospital that is never built isn't very expensive. Neither is the hospital service that is never provided. To the degree that PSRO will prevent hospitalization or units of hospital service, it also belongs under this heading. The federal government invented a new "cost preventive" control when it created its plan for dialysis centers, which I call "specialized service controls." These plans effectively eliminated in advance the expense of marginal competition centers. The "appropriateness reviews" under our new planning act could also have a "cost preventive" impact, if they are ever to become effectively operational, which I doubt.

There are a lot of "cost preventive" controls just in the offing. For example, I think that our Senator Ted Kennedy's idea of controlling the supply and distribution of medical residencies could have a "cost preventive" impact. If we restrain the output of surgeons, the long range result will certainly be less surgery.

As I said, I could talk the whole morning about this, but I wanted to make a couple of main points to reinforce my statement that we have to take this one on because it is just an impossible mess, and what has come out, the moral in this tale to me, and I haven't said this yet, is that nobody is in charge. There isn't any central authority that directs policy and coordinates any of these control thrusts with the result that one is pitted against another.

I know this point of view runs counter to some

philosophy that AHA has had—separating planning from certificate-of-need and that kind of thing—but it has become impossible in Massachusetts. Let me just give you one example.

We are having a crisis in long-term care in Massachusetts, and basically the crisis relates to the fact that the rate setting commission of our great Commonwealth doesn't pay enough to give incentive for any nursing home to give level 1 and 2 care, the subacute case, and while that goes on, a CHAMP program under Medicaid is trying to force the patients out of the hospital, and these two things are running in direct conflict. We are now trying to cope with a new regulation. They just decided that for the patients who are backed up in hospitals—and they are backed up because the nursing homes won't take them—there will no longer be any reimbursement. We are fighting that one in the courts. This relates to another thing in our control system that isn't working.

Over on the certificate-of-need side it has been decided that we have too many nursing home beds, and they are trying to control this by closing them. They also are counting beds on the basis of how many have been granted certificates-of-need, not how many are actually built. In the last three years all the certificates-of-need that have been granted for building a nursing home haven't been built, but they still count the beds. So this kind of thing is just unmanageable, and there has to be somebody in charge. This is one example of what is increasing hospital costs. We can't get rid of these patients that are waiting to get into a bed, and the cost goes over to Blue Cross.

We have another situation that relates to this. While CHAMP is pushing to get the patient out, and while they are saying, "If you don't get them out, we won't pay you," there is every incentive for the hospital to keep them because we are on a flat reimbursement system under Medicaid. Under this, the last days of care get paid just as much as the early days which are expensive, so the administrator has this consideration in the back of his head all the time. Economically, under this system, there is every incentive to keep the patient longer, because the allowed flat rate is a significantly suppressed version of cost. The net result of all this, of course, is nothing. It is just one example of many anomalies in our control system that are as diffuse and confused as this one.

The fifth straw in the wind: There are growing grounds for skepticism about the future viability of the states as the locus for control systems, notwithstanding the fact that we seem to be moving in this direction.

As most of you know, all of the thrust involving the state hospital associations and AHA both have been to try to develop some sensible control system at the state level, and our gut feeling has been that it is better to have it there than down in Washington because we have more influence over it. We can influence it politically more effectively than if it was down there. We all know the problem about that.

But in that connection, let me tell you a story. When we had our series of crises in Massachusetts, and they had to cut everything, one of the things they did was to fire a lot of the people who worked on the staff of the certificate-of-need. They had to fire a lot of the people who worked in the welfare department to administer the Medicaid program.

The rate-setting commission was even cut down on staff. They had to freeze salaries, and some people quit. So while we have this tremendously elaborate and expensive system, the state is getting to the point where it can't afford it. It is very ironic, but they can't afford to run their own controls.

Another point, and I happen to believe this, though it is just my opinion, considering the terrific pressure that is building from all the states, or most of them, is the point that they can't afford Medicaid any longer. I think it is inevitable that Medicaid is going to be federalized. Not this year, but pretty soon, and it makes sense, but as soon as the states get off the hook on picking up a share of the tab, most of their incentives for running control systems will go with it. I just don't happen to believe that it is realistic to think that in the long pull, in the context of national health insurance, whenever that comes, the states really will be in control of controls. It is going to be the feds telling them what to do and them running it within rather tight federal guidelines, as much as we would like it to be the other way.

Another realistic consideration on this subject relates to Massachusetts. Some of your states may not be as badly off as we are, but the bureaucrats that we have are so badly underpaid that it is ridiculous to compare their competence with the people they are controlling, or their incompetence. They don't stay. We have young people moving in and

out who graduated from Harvard and approach their jobs in the bureaucracy as a training ground, doing their Master's thesis by writing another set of regulations for hospitals.

This just isn't very stable. Literally, I can't see the states very soon having the capacity to attract the kind of talent that is needed and the kind of sophistication that is needed to make a control system work very well. I include in this rate review, too.

My sixth main point: In the design of our future control system, the most important and difficult part of the assignment is how to set up a system that rewards quality performance and penalizes poor quality.

The theme of this meeting is "Mobilization for Survival." In the context I am talking about, I think it is pretty clear, and it is already happening, that all of our hospitals aren't going to survive. As a result of some of these Medicaid income sanction controls I described, we have lost four hospitals. I heard just two days ago that two more chronic hospitals were going to be closed. None of this is going to hurt very much because they were marginal. But the real problem as we look down the trail on any system we devise that allocates gross income, the global control to hospitals, is how to reward the good and not reward the not so good. There are a lot of not-so-good hospitals. It is going to be a very political exercise. I have some hopes that the PSRO might help in this area, that is, if it lasts long enough. We might have a handle for saying that you can go up 10 percent in your gross income because you do a first class performance, but look at what you did, and we just can't give you that much more money. I don't know any other handle right now that we can use to get at this.

Point number seven: In the time frame just ahead, when our hospital system gets its squeeze, a solid political position for our field is to develop consumer alliances, getting publicly on the side of patient rights and fighting for their rights to quality and access.

A real fundamental change is taking place in attitudes towards government, as we all know, and it is being judged by the public more by its deeds than by its words.

The game of government in Massachusetts, and at the federal level now, is denying benefits and entitlements and rights. The profound impact of

this on Massachusetts is that the consumers—(and we keep in close touch with them)—the organized consumer groups are now more angry at government than they are at hospitals. This we have exploited.

In the context of the cost control bill I have described, we beat it, partly because we kept close connections with the people who, as we told them, are going to be denied care if the governor gets his will on being able to have absolute control over the hospital system.

This was one reason why we had so much support in our political effort. I say to all of you, and Odin did touch upon this in his discussion, that I don't think it is so hard for hospitals to get consumer support. Good, well organized hospitals are doing it now in Massachusetts. They are learning fast because they have to. They are developing their own consumer movements. Their consumers are their publics, and the auxiliaries have been helpful and the boards. They have established good lines. When an issue such as I described comes up, it is easy to get the support of the legislators on the side of the hospital. This is what has happened, and it is always more difficult, I have observed, for the big city people, and it is true in Boston, to get this kind of identification with the hospital in the urban setting, but it can be done. I think we have to play it because the game now is, "There is only this much money," and then we have got to say over here, "Then there is only this much care." We have moved toward the middle on this because "there is only so much care" gets us on the side of the patient.

We have to be very aggressive about this, and we haven't been aggressive enough yet.

Point number eight: I could talk at great length about this, but I won't. It's the terms of the new alliance with medicine. I think some things are changing here. One of the things that is changing just by process is that more physicians are recognizing their identity with the hospital. They are so frightened with being alone in this predatory environment that they think of the hospital as a protector (witness the malpractice situation in some of our areas). Our game, I think, with the physicians, is to be the supporter of the physician in his professional prerogatives and his ability to carry

out these professional prerogatives as an independent. It is no longer protecting his right to get rich.

We have one issue before us now in Washington in the Talmadge Bill where apparently they are going to get to the pathologists, radiologists and anesthesiologists by cutting down on the ones who are making \$250,000 a year on percentage arrangements. I don't think it is our game to support the staff specialists in this arena, and I think we have to make it clear to the doctors that "We support everything else you want to do, and we want you to practice as free, independent practitioners in terms of your conscience and your commitment, but don't think we are going to be the source of your getting rich." I think that we are almost there in Massachusetts. In other states, particularly the great Midwest, it hasn't changed that much, but it is going to change in that direction.

Point number nine: The bloom has gone off the comprehensive health care rose. I have implied this in other things I have said. This is Senator Kennedy notwithstanding. The reality we face, and again Boston furnishes a spectacular example, is here we have in Boston 30 neighborhood health centers, more neighborhood health centers than any other city in the country. We have the most advanced and well developed system of home care, lots of home care agencies. In the distribution of our Blue Cross caseload right now (and everybody has been saying we should do this) 80 percent of the claims in Blue Cross are outpatient including emergency, and Blue Cross is now almost broke.

The whole argument about primary care is more ambulatory care. We are running out this scenario, and the results as they are evident in our 162 percent expenditure increase that I described are it doesn't save money. The real game is doing what is most important and not doing everything. There are more and more of the pros that recognize this, but the politicians don't.

The tenth point, and final point: I believe a case is building in the area of patients' incentives to stay healthy and it is building because we have to figure out some way to get at this problem.

I think Massachusetts is full of, among other things, hypochondriacs. There are a lot of people that really don't need the service they get, but they like to go and see the doctor.

I happen to believe, for example, that we can

build into our rating schedule for insurance disincentives to smoke. Why not charge somebody a higher premium if they are a habitual smoker?

How about the people that are overweight? Why can't you tell them, "Okay, you can be fat as you want, but don't expect to get off easy on your premium. We are going to charge you 30 percent more." Some things can be done here.

The 55-mile-an-hour speed limit did something on reducing the cost of health care. We can do some things, and we have to think about them. There is some disagreement about whether hospitals should take the lead in that, and I don't think we should, but I think we should be party to efforts to encourage more judicious use of health services.

The big dilemma, of course, is co-payments and deductibles. I don't happen to believe that they deter abuse, and if they get high enough, they, of course, will discourage people from getting needed services.

But I think this is an important area. The irresistible force has met the immovable object on the cost issue. There isn't enough money, and there is unlimited demand, we have to be in there somehow hedging the demand factor.

I happen to believe, and this is my final observation, that our system will continue to grow and get stronger. We will weed out some weak spots.

I think the whole argument about beds is ridiculous. We have had a crusade against beds in Massachusetts for the last ten years, and I think the real answer is moving over on this because of the long-term care issue.

The most efficient way to use a hospital is to fill it, and if there is a chronic, serious problem in what used to be called extended care or subacute care, why shouldn't the hospitals be doing it? They can do it better. Within a frame of reference of limited, known-in-advance income, I think we can do it effectively, too.

One of the things that pleased me happened just this Monday. I got word from my man in the State House in Boston that a senator had introduced a bill to investigate the Massachusetts Hospital Association. In the language of the bill was a statement that they want to look into our whole political action program and the salaries of chief executives of the Association and other relevant things because they are using nonprofit money to have (what was implied) this great influence on decision

making. The reason this pleased me is that I don't know of a better testimonial to what is happening in Massachusetts and across the country and in AHA. We do have power. When we get going on it we will wield tremendous influence particularly using the hospital effectively as a political instrument.

One beef I have had with administrators over the years is they have a psychology of weakness.

They cannot control their destiny, they say. What are they going to do to us next, they ask?

I say that we can influence the outcome a great deal by using these forces that we have once we start believing that we have them, and we do.

Thank you very much.

The New York Experience: Utopia in Shambles

IRVIN G. WILMOT

CHAIRMAN GRAPSKI: New York City is usually ahead of the rest of the nation in almost everything—culture, fashions, art, and now with the evolution of the natural history of its hospital system. It may very well represent where we all will be some years down the pike in the absence of positive preventive measures today.

Irv Wilmot, the Executive Vice President of the New York University Medical Center, will discuss "The New York Experience."

MR. IRVIN G. WILMOT: Thank you, Lad.

David Kinzer, I want you to know that I listened very, very carefully to the pain that you are experiencing in Massachusetts, and it is my considered judgment that you are roughly two years, eight and a half months behind New York.

I would like to comment on the title of the talk which I did not select. I don't know whether to thank Joel May or the committee. I will agree to utopia, although I think when we were living the past, we really didn't consider it utopia. On the other hand, in retrospect, the past does have some utopian qualities over the present.

Shambles, I simply cannot accept. New York is not in shambles, and even if it were, I couldn't admit it as a good New York resident.

Lad alluded to the leadership role of New York, and I think that it is important that I make note of that. I would remind you of the fact that one of the rich traditions of New York is that of supplying innovation to the field.

As you history buffs know, the first pediatric unit in a hospital was developed in New York. New York is responsible for the first radiology department in hospitals. Similarly, the first social service department, and I dare say there isn't an administrator here who isn't grateful and would feel his life very incomplete without the radiologist or a group of social workers around.

So you might keep this leadership role in mind

over the next 20 minutes that I have been allotted to fill you in a little bit on the New York experience.

Unfortunately, the New York hospital experience of the past ten years is not a simple "war story." The complexities and interrelationships of the factors bearing on the industry in New York and which have contributed to its present crisis are many and varied. In total, I'm sure they are not known to any single individual, let alone me.

As testimony, however, to the variability of the industry, to this day, the unevenness of the "hurt" ranges from institutions who have banked surpluses each year to a number who have simply stopped doing business. I should hasten to add that the trend is towards the latter. Trips to the bank nowadays are for no other purpose than to extend the line of credit.

Because it is the "cans of worms" that it is, I simply cannot give you a detailed account of the past decade with any sense of completeness or order. Instead my effort will be to provide a flavor and a feel for the New York situation. To do this I'll summarize briefly some of the conditions present in the spring of 1976 and following that, I will attempt to trace some causal factors unique to New York plus a few that I think we have in common with the rest of you.

In the spring of 1976, New York hospitals are operating with "frozen" reimbursement rates. Rates for the current year have been fixed at 1975 levels. This is for both Blue Cross and Medicaid. At this moment rates remain frozen with no hint as to when the thawing will take place, if indeed, it does at all.

The Commissioner of Health, under powers given to him some ten years ago, has again this year developed refined methodologies for computing payments to hospitals under the Medicaid and Blue Cross programs.

These new regulations provide for a decrease in the ceilings for routine service costs, and I might point out we have been operating under these ceilings or "caps" for some six years now in New York, from a percentage of 110 percent of the group average to 100 percent of the group average. This, of

course, increases the number of hospitals in a given group that will receive less than they have spent.

In addition to this tightening of the previously existing ceilings on routine services, the Commissioner has come up with a new approach. He has developed ceilings for ancillary services.

These again are computed at the median for each group and are applied on a per stay basis, rather than a per day basis. Think through for a moment the interesting ramifications of this approach to mix, intensity and length of stay—to say nothing of the divisiveness generated among hospitals involved.

One hundred and thirty hospitals in the state are finally being billed their malpractice insurance premium for last year. This premium is under the Joint Underwriting Association that was established last year by a special act of the legislature. These new billings that were received represent the final rates for the current period, and it is interesting to note that these final rates are roughly 500 to 1200 percent above the interim rates developed last fall.

Incidentally, the interim rates were based on the prior year's premiums plus about 10 percent. An equal or greater premium will be due July 1st of this year to maintain coverage for the institution. For some institutions million dollar plus cash outlays will be required within the next thirty days.

The contract between Local 1199 and the League of Voluntary Hospitals expires June 30 of this year. Negotiations will begin somewhat before then. However, this pattern-setting bi-annual exercise should prove most interesting in this year of "no money."

The Hospital Association of New York State currently has three separate Article 78 proceedings. This under New York State law is the mechanism by which you sue government officials for malfeasance of office. The three separate proceedings are jointly and severally against the Commissioner of Insurance, the Commissioner of Health and Blue Cross. These are in addition to actions in the courts against the same defendants by individual hospitals and groups of hospitals. I mention this principally as an indication of the prevailing attitude between regulators and regulatees, and between payers and payees. It is considerably less than what you might call a warm relationship.

These then are a few of the indicators of the

quality of hospital life in New York in the spring of 1976.

I would like to turn now to some of the events of the past decade which may, or very honestly may not, explain the current state of affairs. They are thought to be causal, but certainly are not so guaranteed.

One of the very powerful and insidious forces imposed upon hospitals in New York is the regulatory function of the State Department of Health. Regulation as we know it in New York got started in 1964 with passage of the Metcalf-McClosky Act. This bill provided for "Certificate-of-Need" procedures and converted the voluntary planning that had been underway for a number of years into one of state control. In 1965, the Folsom Commission, appointed by Governor Rockefeller, completed its task of evaluating the cost of general hospital care in the state and came forward with some fifty recommendations that were aimed at (and I quote from the report) "moderating, monitoring and meeting the cost of hospital care." These recommendations were quickly converted into law the same year by passage of Article 28 of Public Health Law. This law centralized the regulatory function of hospitals and health facilities in the State Department of Health and bestowed upon the Commissioner very, very broad regulatory powers. Four years later, in 1969, the Legislature passed a "cost control" law which mandated that the Commissioner of Health develop payment rates for both Medicaid and Blue Cross that were "consistent with the efficient production of hospital service." The cumulative result of this legislation is an awesome and frightening concentration of power in one office in Albany.

The flow of regulations from the Commissioner's office under these laws is endless. I think the New York list would equal or surpass that that Dave has put on the board for you.

They cover the entire gamut of hospital and health facility construction and operations ranging from building standards, capital cost limitations for both building and equipment reimbursement, staffing patterns, mandated services, specified accounting practices, qualifications of personnel and so on. Regulations traditionally have been adopted and enforced without consultation with the industry

and without notice or the opportunity for comment.

I might add parenthetically that last year we did get a new piece of legislation passed in Albany so that effective this fall the Commissioner is required at least to publish 30 days ahead of time the proposed regulations for comment by interested parties.

Another element of the hospital scene over the past fifteen years has been the birth and growth of hospital unions. Starting in 1959 with the recognition of Local 1199, the union movement in New York City has grown and prospered. 1199 is the largest of these. However, through a very liberal state labor law in effect prior to the inclusion of hospitals in the NLRB, practically all professional and nonprofessional groups within the hospital have union structures available for them for representation if they so choose. Included are technicians, physical therapists, occupational therapists, nurses, unskilled labor, clerical personnel, house staff, attending physicians and on down the line.

Without question, the labor movement has contributed significantly to the increase in costs in New York. In 1963 the average weekly wage for hospital workers in New York City was \$52.00 per week. This, incidentally, was significantly below the national average.

In a ten-year period, this rose from \$52 a week to \$153 a week, and three years later in 1976, the minimum weekly wage for hospital workers is \$181 a week. No one will deny that some movement was needed back in 1959, but the momentum generated created a little greater apogee in the cost curve than most of us anticipated.

Another ingredient of the New York scene is the largest Blue Cross Plan in the country. Its presence coupled with governmental programs of Medicare and Medicaid creates a situation where institutions derive the vast majority (not infrequently above 90%) of their income through third party payment mechanisms. The combination of predominantly third party reimbursement coupled with the regulatory powers of the Commissioner of Health has created a constant squeezing of income in the hospital system since the effective date of the cost control law in 1970.

Unfortunately, both Blue Cross and state officials seem quite unconcerned about the deterioration of hospital services. Big Blue seems content to accept whatever premium increases the Commissioner of Insurance authorizes as long as the Commissioner

of Health sets his payment rates accordingly. Interest in the maintenance of the premium dollar and reserves, and not particularly genuine interest in service to subscribers seems to be the prevailing attitude. The Commissioners apparently believe the system is still fat and can continue to absorb all of the financial insults they can and do concoct. In my opinion, the day of reckoning is not too far off.

Since the enactment of the cost control law in 1969, the hospital industry of the state has been under constant income constraints. The economic stabilization program of the federal government in the early Seventies compounded this process and created a double jeopardy situation for New York hospitals. In addition, prospective rate setting which also came into being in 1970, and which, incidentally, has never been allowed to develop to the full bloom of its original concept, has contributed further financial abuse to the system. The apparent reimbursement posture of the state is to continue to cap income with the conviction that individual institutions can survive even with increasingly less money to spend. For many institutions, particularly those with significant ambulatory care responsibilities, for which income is most sparse, survival has been a most difficult accomplishment. It would appear at the moment that the reimbursement posture of the state will continue and that hospitals will be in a survival mode for the indefinite future. Non-survival for some will simply be a reality.

In addition to these features of the hospital scene that I believe are peculiar to some degree to New York, the city and state share also in some of the industry characteristics found throughout the country.

New York, like several other states, is in two parts: The rural, upstate area, and metropolitan New York City. For the most part the upstate area hospital services are typically those of rural America, the exceptions, of course, being several, and you can count them on one hand, teaching institutions in Albany, Rochester, Syracuse and Buffalo.

In the New York Metropolitan Area, there are very wide institutional differences. Six medical schools have their locus within New York City limits. Each operates tertiary care centers and together they account for well over 10 percent of the total house staff trained each year in the country.

The city, as you know, has a very large indigent

population that is serviced principally by institutions who serve as both doctor and as hospital. Other hospitals, both general and special, and ranging in size from 50 to 1000 beds and numbering about 130, fill in the city landscape. With these vast differences in size, in purpose and in function, and with the natural differences in the upstate and downstate perspective, the difficulties of arriving at common problems, let alone common solutions, is next to impossible.

Each institution in its own self-interest does what it perceives as the appropriate and right thing for it to do. The presence of common ground on which to combat the incursions of Blue Cross and government regulation is but a small island in a very, very large sea of substantial differences. Defenses against the enemy, whoever he may be, let alone counterattacks, are difficult to mount.

The problems connected with achieving collective action among groups of hospitals have a counterpart in the microcosm of the individual institution. As all practicing administrators that are present today know from bitter experience, the difficulties and pitfalls in achieving institutional postures fully supportable by physicians, board members, and administrators in the community are many. The ability of an institution, however, to develop a mechanism whereby institutional positions can be taken is in my view crucial. The adjustments necessary now to institutional program, in terms of the allocation and reallocation of resources and other internal issues make this capability mandatory. If one is to view the future with any sort of realism at all, the viability of this function of an institution will form the base for its survival.

That institutions do have instincts for survival is, without question, true. The intensity of this instinct may vary somewhat from institution to institution. The variations, however, are not great and for the most part the survival instinct has great force.

This characteristic in an institution frequently serves to interfere with the ability to function collectively with other institutions and at the same time can become a counterproductive force in internal affairs. Because of the importance of an institution to the economic, social and cultural well-being of that body of people, which, in fact, are the institution, survival becomes the bottom line, surpassing by any measure any interest in collective action, good for the whole, et cetera. For this reason

political bodies historically have been unwilling to confront or force the nonsurvival of an individual institution directly.

Another feature of the hospital which makes it especially vulnerable to the kinds of abuses currently being imposed in New York is the nature of its product. Being a personal service, the hospital product has great flexibility in terms of its composition. It is extremely difficult to objectively determine the qualitative differences of varying staffing patterns, or of what constitutes a full range of diagnostic or therapeutic services.

Regulators are very much aware of this special supply nature of the hospital product. It is only because of this characteristic that the "constraint of income approach" to controlling expenditures works. The survival instinct forces institutions into an adaptive mode, the result being a withering away of the product, as income is reduced. The risk, of course, is a withering to a non-product, or ultimately, if carried to the extreme, an institution and a system not capable of delivering even minimum services.

A final universal characteristic of hospitals that I would like to mention, and I do believe it only needs a mention, is that of public attitudes. The late Forties, the Fifties and the Sixties saw a remarkable growth and development of hospitals and their service capabilities. Public attitudes, generally speaking, were nothing but positive, and institutions, in fact, could do little wrong.

The Seventies has seen a reversal in this attitude, almost 180 degrees. Government, be it legislative or executive, and I won't comment on the judicial, although I believe the judicial attitudes tend to follow social attitudes, tend to view doctors and hospitals with a universal negativeness. The same can be said of employers who pay most of the health bill, and in fact, even can be detected in that large number of grateful patients, who do not have full third party coverage. Much could be said today about the reason for this change. However, for our purposes, simple recognition of the fact will suffice.

Many might feel a discussion of the New York experience would be incomplete without mention of the much publicized New York financial crisis. That I do not limit to city but state in addition.

The crisis is real. I can assure you of that. Its magnitude is probably greater than any of you here imagine, and it is certainly not over. The crisis, however, in my opinion, had no role in creating the experience under discussion today. Its existence, however, has added intensity and urgency, and perhaps some irrationality, to the process and state of affairs described.

DISCUSSION

with **Odin Anderson, Dave Kinzer and Irv Wilmot**

MEMBER: I live right across the river, from Irv Wilmot in New Jersey and I have watched with interest what has been going on. I used to sit on a review committee of Blue Cross until they decided they didn't need those. One thing I have observed is that the regulatory climate is forcing the administrators, the decision makers, into a shorter planning horizon. Now we are making decisions about expenditures for this month and not worrying about the expenditures that might be helpful in the next year or the year following. Consequently, what is going to happen to the hospital plant in New York City? Will the result be the same as the control of Consolidated Edison that allowed them to get in the position where they couldn't replace their plant resulting in the big energy crisis of the 1960s?

MR. WILMOT: Without question, you are right.

The survival mode is really a short term adaptive process, and I have tried to allude to that in my view for the individual institutions. The ability of an organization to develop an internal response mechanism that can respond to these various incursions into our business and constraints that we are meeting is imperative. You simply can't sit around in the future like we may have been able to do in the past taking three months to develop an institutional posture. The need for executive decision making on the institution's part is crucial, and most institutions are poorly equipped to do this. Of course, the regulators take full advantage of it.

In New York, and I guess it is true in a number of areas of the country, we have hospitals that probably should go out of business. The Greater New York Hospital Association endorsed a list of voluntary institutions, which happen to be its members,

The forces responsible for the New York situation are not indigenous to the state. They are present in all hospitals, in every state, and in the nation as a whole. In its traditional leadership role, it would appear that New York has done it again. The course we have charted will most likely be followed by all. I'm not at all sure we want the gratitude you undoubtedly wish to express. Thank you.

that should be phased out of business. This is a remarkable political move. As you know from the papers, the same thing is taking place in the municipal system. Our problem is that we just can't convince those calling the shots, and of course, in New York the power is really centered in a commission, of the necessity of closing these hospitals. The government and the whole political process has control over 90% of the income, and they can be pretty arbitrary and capricious.

My personal view is you are going to see a number of hospitals in New York go out of business. When one or two good ones get in real trouble, then you may see some change in the attitudes.

MEMBER: What has happened to the quality of care in New York as a result of the crunch? Are there ways of identifying the impact on quality?

MR. WILMOT: I don't think a lot has happened to quality. There are as you all know, great variations in quality. The hospital product is a very flexible thing, and the human body will withstand a lot of abuse. There is a tremendous range between survival and the kind of care that we would like to have for our family and ourselves.

But in this sense maybe the politicians are right, perhaps we have spent too much money for quality. With the imposition of ancillary cost ceilings, hospitals with costs below the ceiling are going to make out like bandits. Tertiary care hospitals, having the EMI scanners and the like, will be forced down to the level of the ceiling. That system carried theoretically to its end, would produce a single hospital rate for every institution irrespective of size, program or anything else. But even then, I can't detect any differences in the quality.

MR. KINZER: In Massachusetts, our costs have gone up faster than most states with more regulation, and I think our quality is still going up. At least, I like to believe that. The hospitals that have been zapped, were marginal, and actually the system is a little better as a result of these actions.

MEMBER: Mr. Kinzer, I would like to pursue your comment on the federalization of the Medicaid Program.

You saw federalization taking place in the control process. Yet, this seems to run counter to the political trend in the nation right now.

A couple of days ago we had two visitors from Washington, one was the Chief of the Domestic White House Council. They were brought out by AHA and others, to view the field to get their feet wet. I said that we viewed the federalization as a blessing rather than as something to be avoided. It came as a great surprise to them.

I am interested in your comment.

MR. KINZER: First of all, and I don't think our experience is unique—the problem with state participation in Medicaid is that in an economic slump, in most states, as needs go up, capacity to meet them goes down. The economic arguments for the Federal Government taking it all over are strong.

I have talked about this with Bob Youngquist at breakfast. The Federal Government still has the capacity to borrow and borrow and go into debt deeper and deeper. They can finance these humps in the economy that the state can't. In the current political context the governors constitute a very powerful force supporting federalization. Our governor is in the forefront of this. He wants to pass national health insurance as fast as he can and get off the hook. I don't know when it will happen.

When I speak of federalization, it makes a lot of sense to me. It is absurd that we get people to come to Massachusetts from Alabama because the welfare program is so much better. If there are poverty and needs in Alabama, they should be met on an equal basis with other parts of the country. I am stating my own philosophy as well as my conviction that the economic forces within the states will eventually prevail to make the feds take it over.

MEMBER: I think that with 627 billions of national debt, 414 billion proposed by the Congress

for the next fiscal budget starting in October on the new system, and 50 billion of that in deficit, we are close to the end of seeing the federal commitment grow. Some of the federal congressmen that I have talked to aren't very happy about picking up the tab for anything else. They are beginning to realize that, worldwide, no government has had enough money to pay for all the health care that the people will use. We are going to have to deal with this on a different basis.

CHAIRMAN GRAPSKI: We have with us the Deputy Commissioner of Health for New Jersey, David Wagner. What is your response to this?

MR. DAVID WAGNER: Mr. Kinzer, I enjoyed your talk very much. First, I think that is good to point out the foibles of we regulators and the regulatory system. I think that it is also good for regulators to come to meetings like this and receive their whipping sometimes. I think it is important for both sides of the equation to talk, argue, fight and work it through.

I notice Mr. Kinzer said he had been in meetings with the Governor. I presume that he met regularly with the regulators of the state as a representative of the Hospital Association. That, for any of you who are from the Hospital Association, is extremely important.

We have never had the unusual situation, as in New York, where we could pass regulations without somebody saying something about them. We certainly try in our regulatory process to involve the administrators and the Hospital Association on various task force advisory committees. The thing that disturbs me a bit is, though I am a friend of the Director of the Hospital Association, it is more often that we go to the Hospital Association and the hospital administrators to be involved in our process than they come over to see us. I think it is also fair to say that in the year and a half that I have been in New Jersey, I haven't seen the Hospital Association very often seeking our involvement. I certainly hope that you do that more often.

There are a few things I wanted to comment on in terms of your straws in the wind which I thought were rather accurate. First, I certainly want to say I

appreciated the fact that you want me and others to be better paid. I think that was your best point.

I agree with you that there is going to be continuing pressure on the industry over the next few years, whether you and I like it or not.

I agree that controls are a bit out of control, and that we have to do something about that long list of regulatory agencies that we have up on the board.

As an individual who has been trained in political science and not in hospital administration, I feel we have to learn the lessons of regulation in other industries in the United States which really haven't worked out too well.

I agree with you that rate setting at the state level is going to be a rather short-term thing. The system will ultimately become a federal system. It is not necessarily bad that it started at the state level; it enabled us to have a certain amount of experimentation, learning and pain. I do disagree on one point, I don't think the consumers are ready to get behind the hospitals and fight a good fight. Perhaps they are in Massachusetts, but I think in New Jersey and around the rest of the country that we do not love you nor the medical profession at the moment, and probably won't for a few years yet. Nevertheless, I certainly would encourage you to try.

Hospitals should be involved in extended care or subacute care. There is a noticeable reluctance in New Jersey to enter this field, perhaps because of concern about the reimbursement aspects of that program. Still as a regulator, I would certainly much rather deal with you in extended care than the folks I have to deal with now. I certainly would like to encourage you to pursue that avenue more assiduously.

MR. KINZER: I don't think the consumers love us. They just hate us less than government! It relates to some of the realities we must face. The government and the bureaucrats are in a period of being forced to make unpopular decisions. I don't envy my Governor; his job is even worse than mine right now. I spend a lot of my time talking to government officials from the Governor on down. One of the problems that is built into the system that I didn't mention is that every time there is a reelection, there is a new set of bureaucrats. What is really involved, and I don't mean to be sarcastic about this, is the re-education or the de-education of new bureaucrats. We have the key people in our

administration now. They just came in about a year ago. They are all 31 years old, and they have very powerful positions with almost no experience in this utter mess that they have to administer. The real problem involved, is that it takes at least two years to get on the same wave length talking about the problem. The unavoidable tendency of the new bureaucrats when they come in with these vast responsibilities and no experience, is quick solutions. Quick solutions, as I tried to indicate in my example of long-term care, are often self-defeating. Their solution in this instance is not to pay us for the patients that are sitting in our hospitals waiting to get into a nursing home. This is not a solution—it is a way of avoiding a solution. One of the things that I would like to do would be to get together right off with every new administration, this new crew that comes in, and take them in an organized way into some hospitals to find out what is real about all of this. Perhaps some of the absurdities that happen as a result of trying to administer these regulations without such exposure could be eliminated. But there is in Massachusetts, at least—maybe there isn't in New Jersey—a tradition of adversary relationships. The one thing that they don't want is for anybody to get out of their little office and go and see what is going on in the real medical care world. Otherwise, they are afraid they will get captured by the system. So I agree with you Mr. Wagner, there is a tremendous need to keep these dialogs open. I do my best, but it is hard.

MEMBER: It seems to me that there are at least two forces that are contrary to moving regulation to the federal level. First, neither the State nor Federal government is anxious to compete for the opportunity to tell people that they can't have what they thought they were going to get.

The second reason is that it is my observation, generally, that the level of discontent about medical care rises with the level of expenditure.

So that the people in rural areas who don't get very good care, the way we evaluate it, are relatively content with it; whereas in New York, Boston and Philadelphia where the level of expenditure is high, the people are relatively upset.

To federalize that situation, is a circumstance that is calculated to make everybody mad, since the people in the urban environments who want more

are going to have to be told that they get less, and the people in the rural environments who are relatively content are going to be upset because they want out of the system the same as the other people get, sort of like competing for highway money. So it seems to me there are at least those two forces against the Federal Government getting involved in regulation more than they already are.

MR. KINZER: Are you saying it is unwise for the state to shift the financial obligation to the Federal Government?

MEMBER: No, I think from the state's point of view, they would love to have Medicaid federalized. There are many reasons for doing that, but it is hard for me to imagine from a Federal Government perspective why a Senator, President or a Representative would want to take on this can of worms. There are not any votes in it as far as I can tell, and it is inclined to make everybody mad.

I have a good personal friend who is the administrative assistant to one of the Senators, and he asked me what position I thought they ought to take on national health insurance. I said, "I think you ought to be publicly for it, and privately do everything you can do to keep it from coming to a vote," and, as far as I can tell, that is essentially what is going on.

MEMBER: It seems to me we will be in a very dangerous situation if we have the largest purchaser of health care setting rates. I think we have all tried to avoid that. I don't know what the answer is. I still favor the independent state commission to centralize this activity. I agree with you that piecemealing of controls is a great problem, but if we get into single government control of rates and what-have-you, it is going to be New York revisited. How do we avoid that?

MR. KINZER: I don't know. I think this is a classic dilemma. One of the reasons I am glad to be in Boston is it means I am not in California and New York. I share your fears, but I don't objectively see it going in any other way.

CHAIRMAN GRAPSKI: Mr. Wilmot, how about you? Did you want to respond to the New York situation? Is there a corollary here?

MR. WILMOT: New York is an example of the government setting reimbursement rates. In my view, we are having a very difficult time combating the consequences of it. I don't think we have a system to combat them yet.

MEMBER: Odin Anderson, you are a student of health care systems around the world, and I realize the United States doesn't ask advice from any one, but is there any prototype, anything going on in the rest of the world in health systems, that can be of use to us, or must we flounder through this ourselves? Other than reading your books about this, in a word, is there anything we ought to be looking at that could give us some guidance?

MR. ANDERSON: There isn't really anything solid that you can be looking at, because the other countries, as I said in my talk, are entering the same stage.

I am thinking particularly about planning, because they haven't been planning before. They have all lived in an expansionary period, even in England, and so they haven't thought seriously about resource allocation.

I suppose you can always look at the Swedish experiment or rather the actions there, but it is a completely different kind of culture. It is a culture of rationality, of looking at figures and data, besides, everybody knows each other. Their economy is still growing, so that there is nothing to learn methodologically other than to learn some wisdom. I feel I am a lot wiser having studied the system, but have few practical observations other than I think the system itself is practical.

I also find that systems somehow do not learn from each other. We each have to go through every stage of accommodation and compromise because each generation of doctors or hospital administrators, even patients, are so accustomed to what we have, that there has to be a break-through of thinking about it. I can predict, I think, what is going to happen here by looking in large part on the international scene (particularly on the Canadian scene, which is closer to us politically and in the structure of health services) but if any one tells you from abroad that they know what they are do-

ing, in any valid, rational sense, that is nonsense. They do what they have to do, and we are doing what we have to do.

It really boils down to how much money the body politic is willing to spend through a very crude decision-making process.

Having answered your question so explicitly, I would like to take this prerogative while I am on the microphone to ask Mr. Wilmot a question regarding his institution. The same question applies to Mr. Kinzer regarding a group of hospitals.

Do you have, or can there be, a strategy of retrenchment? You are all expecting retrenchment. Are you just sitting there? Aren't there some things that you think are less necessary than other things so that we can over the next five years plan an intelligent strategy of retrenchment?

MR. WILMOT: We have been planning for five years. In fact, we have been executing for five years. The only strategy that we have developed, and it is not very effective to be very frank with you, is that of attempting to develop an internal *modus operandi* to respond to the external factors. When you get into non-clinical areas, it is not hard to reduce the level of housekeeping. It is not hard to take another entree away from the food department, so that a patient can only choose two things instead of three. One thing we are looking at now that will save us \$300,000 a year is whether we can serve a blue plate special and get away with it. In other words, go from what has been the great thing in hospitals, selective menus, down to one entree.

Where most institutions of today, and mine is included, have been totally unsuccessful, is in attempting to constrain in any way clinical programs or clinical services.

MR. ANDERSON: Would you have a suggestion as to what should be cut back in talking about your medical staff?

MR. WILMOT: Very frankly, I am looking for 2 million dollars savings this year to break even.

Right now, we are a large institution, but we still spend \$300,000 a year on what could be called reference laboratory work. This is exotic, esoteric work that probably has some historical value, though it probably has very little value for the immediate care of the patient. We are thinking about simply

doing away with it. But tackling the problem of constraining costs in your open-heart surgery program becomes very, very difficult, particularly when the Commissioner is pushing regionalization. Yet at the same time, they constrain the income so that the ability to cope with the clinical changes, given the organizational practices we have today, is diminished. Ultimately, I am going to sit down, and decide where the money should be spent, and the Board of Trustees is going to bless it, and the medical staff is going to gripe like hell.

MR. ANDERSON: You have more of a strategy than you gave yourself to have.

MR. WILMOT: That is right.

CHAIRMAN GRAPSKI: Mr. Kinzer, how about the group of hospitals' view?

MR. KINZER: It is always easier to have a strategy globally than if you run a hospital like Mr. Wilmot. Starting with the assumption, which I think is real, of a limit to income to the hospital system, I think the game for us is to build our political strength as fast as we can as an offset against the process that Mr. Wilmot talked about. Apparently a bureaucracy and a Governor just don't care what the hospital thinks. This is not the situation now in Massachusetts because our hospitals have done a good job in getting local support from their legislators.

The offset, or the balancing force against the bureaucracy is elected representatives. We have a lot of support there. It is what I describe as a counter-force that gets us more money than we otherwise would get.

I am more optimistic than Mr. Wilmot. Assuming we are successful in the political part of our game at the hospital level, we will not have to give up too much in the way of essential services that are of a high quality. The inevitable corollary of all of this is the rationing of services. There was a great article written in the *New England Journal of Medicine* by Dr. Howard Hyatt which is called, "Who Shall Guard the Medical Cons?" He did some arithmetic, and projected the incidence of open-heart surgery, assuming a steady increase in the number of surgeons and steady increase in the number of hospitals that do it. Over a short time

span, I forget what it was, it would cost 100 billion dollars a year.

I don't see the political system really functioning in the decision of who gets that surgery and who doesn't; who gets the pacemaker and who doesn't. I am afraid I see the hospital doing this. I think these decisions will be made and they will be made conservatively. It is going to be tough, but we simply can't afford all of this, that is all. I am more optimistic about the capacity of the system to adapt and still maintain the quality, than Mr. Wilmot, but I look at it more cosmically. I guess.

MR. WILMOT: You must develop your prior strategy. Somehow you will preserve the essential good services at good institutions, but you are going to change the character of good institutions through

the insidious process I described previously, as long as you are willing to support the sub-par hospitals that are spread throughout the system.

Now the challenge to Government is to get those hospitals out of the system. I recognize that is a politically difficult job, and it has legal implications and an awful lot of factors. But there is a great deal of money spent in these smaller institutions.

CHAIRMAN GRAPSKI: I am sorry. We have actually exceeded the time that was allotted to us and must adjourn. I want to thank our three excellent speakers that we heard this morning.

Mobilization for Survival: I. Interhospital Alliances

JOHN M. DANIELSON

CHAIRMAN RONALD G. SPAETH: This morning the background work was laid for us with three very good speeches regarding Utopia. I think it is more like Dante's Inferno.

We have this afternoon the issue "Mobilization for Survival," and three troop commanders that will lead us through this.

The first speaker for the afternoon session will speak on "Mobilization for Survival: The Interhospital Alliances," the multi-hospital system, the philosophy which lies behind them, the problems of organizing them, and justification for their existence.

The first speaker is Mr. John Danielson, Executive Director, Capital Area Health Consortium, Newington, Connecticut.

MR. JOHN M. DANIELSON: They sent us this thing that tells us what we are supposed to do, and since none of the other guys followed their instructions, I decided that I wasn't going to follow mine either.

I don't know anything about mergers, and I don't know anything about hospital systems, and I certainly don't know anything about acquisitions. So I thought maybe I would talk about these in passing and get to the issue hopefully that we know something about.

I was watching David, and considering the subject he was on, I couldn't help but think of him sort of representing us as that rooster. The farmer had significant difficulty getting his hens to lay eggs, and he went to a poultry man. He heard that this guy had some super roosters, and he bought one of those for about 5 thousand dollars.

The guy said, "I can guarantee you that if you can keep him alive, he is just going to be so productive that you will get that money back in the first year."

He bought him and put him out there on the farm and got up the next morning. Gee, there were eggs all over the place, and the chickens were cackling and happy.

He thought, man, that is going to be great. He went to bed and got up the next morning, and the chickens were cackling and happy, and there were eggs all over the place. The ducks were cackling and there were duck eggs all over the place. He thought, this guy is getting a little over-active, and he is really a pretty big investment.

He went to bed and got up the next morning, and the chickens were cackling and there were eggs all over the place, and the ducks were laying eggs all over the place, and the turkeys now really looked very happy, and there were turkey eggs all over the place.

He began to get worried, and he got up the next morning and everybody was laying eggs, cackling and happy, but he couldn't find a rooster.

He looked around and he said, "Gee, he must have done himself in." He looked out over the back forty, and there were some buzzards flying around over there.

He said, "I knew it. I knew it," and he very sadly went out to get his investment, and sure enough, there he was with his feet straight up, wings out flat, and he reached down to pick him up, and the rooster opened one eye and said, "Hold it right there and back away. I am okay. If you are going to play with buzzards, you have got to play the game their way."

I would like to lead off by just calling your attention again to something Odin Anderson read to you which I think is probably the most significant part of 93-641. It is, in fact, the intent of Congress. It is the ten national health priorities as listed by the joint committees of the House and the Senate, and it is the intent of Congress. In my experience, if you fulfill that intent of Congress, you can bend the regulations so they look like pretzels, and you will be okay.

It is when you follow the rules and regulations to the letter, but you destroy the intent of Congress, that the Senate Finance Committee will have you for lunch.

I would like to call your attention to those ten simply from the point of view that at least one, two,

three, four out of the ten national priorities in health virtually mandate consortia or multi-institutional systems. So if ever you were going to follow the intent of Congress, you simply cannot ignore the issue of the development of multi-institutional systems.

The second priority of the ten is the development of multi-institutional systems for coordination and consolidation of institutional health services.

The third is the development of organized systems for the provision of health care.

The fifth-priority is the development of multi-institutional arrangements for sharing of support services necessary to all health service institutions; and the seventh priority is the development by health service institutions of the capacity to provide various levels of care on a geographic and an integrated basis. That is your license really to do the job, and the question is how do you do that.

There are some very basic and long-standing concerns. There are more than four, but I am going to list four of probably the most difficult.

One is concern for the loss of autonomy. The second is a concern for the lack of responsiveness if you create another level of authority, and consortia or multi-institutional organizations really ought not to be organized to constipate the decision-making process. That is a real concern.

Third, is that it threatens and it tends to threaten the viability of the institutions. At least, that is what is part of the concern, particularly the financial viability, through the notion that if you put institutions together, the idea is that you carve them up, and you cripple them on the basis that there ought to be only one gas pump in Manhattan.

The fourth concern is the extraordinarily high expectations that one has if you combine that kind of power structure, namely, in our case 200 million dollars of operating budget, 3500 beds, 2500 physicians, a reasonable length of stay (excluding the Institute of Living, which is a psychiatric institution), and about 82% occupancy, most of them running higher.

So those really are the largest concerns except for one that may be even more fundamental. Not very explicitly put, when you build a consortium, but is the underlying problem, and that is who is going to become more important, the consortium or its members?

The visibility of the consortium is a power source,

even though its members tend to be its power. The implication is that we couldn't have done this if it weren't for the consortium, and that is a real worry on the part of the Executive Director, let me tell you, when you are dealing with the hospital administrators, particularly.

I would like to run through the responsibility of the other kinds of multi-institutional systems and get at something that I really believe I was asked to do, and that is look at our kind of consortium.

I really believe that we have developed over a period of time multi-institutional systems that lead to the consortium I am going to describe to you, because first of all, we developed chowder and marching societies of hospital administrators that met for breakfast, or once a week had dinner together. I belonged to a couple of those here in Chicago. They were really places that we could tell each other our problems, but that was the beginning of sitting down together. We decided what we were going to charge, what kind of pay increases we were going to put in, and we shared that with the big six.

The second is to develop councils for administrative economies, joint purchasing. These are largely councils that deal with multiple contractual agreements that are reasonably easy to vote up and down and to demonstrate in the show-and-tell process that by putting the institutions together, you "save money." This is what I call the organizations to buy brooms better. But it is an important beginning, the issue of the economies of administration by joining.

The next was the land developers. These are land development corporations. At least, that is how they start. I always have to be careful about this because I tell George Cartmel that his consortium was developed by a land development corporation. When things are so bad in town, and you are in the blight area, you get the mayor and everybody to condemn the housing around the institutions, and then you work on a kind of big land development, and you put all of the hospitals around there, and then from that you go some place and begin to do some of those other things. It was an important issue, the issue that there were hospitals that needed to be totally replaced, land that needed to be developed,

and they began to be brought together on that basis.

The next group that developed, and is now really a very active group, are what I call the hospital systems.

I really classified them into two groups. One is the church-related hospital system that tends to bond them together for purposes not unlike the consortium I am going to describe, to do whatever they can do together and tend to move towards some central management office that can make some major policy and management decisions for the group.

The other, and probably more effective in terms of dollars and in terms of economics as far as the health care system is concerned, is those hospital systems that are dominated by a single strong institution which buys up through management contracts or actually physically buys up institutions and puts together a hospital system.

Probably the two right off my head that I could think of most prominently would be the Samaritan Health Services in Phoenix and the Greenville Hospital System. There is a subservient role on the part of the smaller hospitals, and very clearly, they cannot regard each other of equal competence since one is dominant and tends to lend its great expertise and support to the others.

Now the Hartford Consortium is different than that, and it may be an evolution out of all of those.

I have to now give you some conditions for understanding where I am going to be going with the rest of the paper. If you are going to put together a consortium that deals largely with organizing the existing medical services, the resources of a group of institutions medically and deal with the question of maldistribution, the question of access to those resources of a targeted community and/or maintaining a strong leadership role, sorting out needs of health rather than acquiescing to demands and do that on the basis that you essentially are responsible for maintaining a perpetual inventory of the health status of the community, and that with all of those resources, you can do something about this "health care delivery system" that everybody writes about, you must be able to get a handle on the fact that we are talking about self-determination of these institutions and their position in the public interest.

Now we maintain that there is nothing wrong with being self-serving as long as you are self-serv-

ing in the public interest. It is only when you are self-serving and not in the public interest that we are in trouble. We seem to apologize for the whole of our expertise since a very small part of it has been self-serving and not in the public interest in our opinion.

The conditions that need to prevail, if you are going to put one of these kinds of consortia together, I believe are the following:

First, that the institutions that you are dealing with have medical practice within them and medical practitioners within them that are uniformly of high quality, so you have got no "pus pockets" to deal with.

I am going to come back to the reasoning for this.

Second, that the institutions are reasonably well managed, hopefully very well managed, and that they are reasonably well financed.

Third, that you have no "cripples" in the group, because where you have "cripples" in the group, you have an insecure institution. I am going to discuss what insecure institutions can do to one another. The sense of merger enters into the consortium when you have "cripples" on your hands.

The Hartford Consortium is a classic. I think Dick Wittrup would agree that the smoke screen of the five strong hospitals originally in the consortium of Mass General and Children's and Beth Israel and that group really was the protection and screen behind which you merged the three "cripples," the two Brigham's and the Women's. There is nothing wrong with that. It is just a different agenda.

The fourth is that the targeted population to be served is identified by institution, either be it ethnic in the case of Mt. Sinai, to some degree, or religious in the case of St. Francis, or by some special relationship. The University of Connecticut, a state-owned university teaching hospital and medical school with Children's being rehabilitation, VA being Federal, the Institute of Living being a psychiatric, so that you are not dealing with the issue of sameness, since sameness will tend to preclude the ability of the institution to get to the table, to regard each other of equal competence which, in a moment, I am going to hope to prove to you is a necessity if you are going to make these institutions work together.

Now when this group of institutions decided to bond themselves together, they did it without the

VA, but essentially these are all the hospitals in the Greater Hartford area. There are no others. So it has an enormous advantage, and they fulfilled the criteria that I have just suggested to you.

Prior to hiring an Executive Director, they sat down and wrote a set of bylaws, and didn't expect the Executive Director coming in to take the leadership role in setting the objectives and purposes of the consortium. They did that first; and they wrote the bylaws, and then sent the bylaws out to a group of people that they thought might be the Executive Director, on the basis of one question:

How would you manage this based on these bylaws?

The most important of the bylaws, would be under the powers of the Board of Trustees. Let me read you Item C under the Powers: "that the power of the Board of Trustees of this consortium will be to monitor the quality of patient care provided by its members, to prescribe the standards of patient care with specific reference to preventive care, inpatient and outpatient care, and alone or in cooperation with others, to implement programs designed to attain and maintain the highest standards possible amongst its members in all areas of patient care."

"To monitor and set the standards for patient care." When I went up for the interview, I put a little thing out beyond that. I said, "How and by whom?" But that simply is the guts of this consortium.

Now I will come back to those powers, as I go along.

Of all the sections of the bylaws, for that matter the charter itself, probably the most significant, as I suggested, is in the powers of the Board of Trustees. From the very beginning, those powers tended to set the agenda for what was going to happen in the first year of the consortium. That is, that they would spend the first year working on the decision-making process, that that was the most critical thing we could accomplish. Most consortiums are too concerned about justifying why they have a decision-making process, and really never get to the point where they know how to develop a good decision-making process.

Now it was not to be a vehicle for merger. It was not to be a hospital system with a single dominate hospital. The academic medical center, although affiliated with all these hospitals for their educa-

tional program prior to the consortium, could not be the hub of the consortium. It was but a single spoke for a single territory of that wheel. Nor could it be the most powerful, richest, fattest and most famous of the institutions, Hartford Hospital. What scared the heck out of everybody that really the father of this consortium was Stuart Hamilton, and they couldn't believe that he went into the pool first to get wet. They figured he must have had some kind of a special suit on that he would change after he got in the pool, which didn't happen.

It was also not to be a chowder and marching society (which, by the way, they did have and was helpful to them in developing this), and it was not to be an arena to make unpopular and difficult decisions outside these individual hospitals, so that the administrator could be held blameless on those tough decisions.

Right from the beginning we decided that could be a disaster since if all the tough decisions were going to be made out of the consortium, I would end up implementing them. If the physicians in the institutions realized that the hospital administrators in their ordinary structures within their institutions were not solving the toughest problems, they would bypass the management of the hospital and come right to the consortium, and I would have them all. So the idea was I stay out of their business, and hopefully they would stay out of mine.

It was to be a tripartite union of the expertise of trusteeship, the medical staff, and the administrative structure. And in my view an arena in which the medical staffs, without threatening the management of any one individual institution, could, in fact, begin to get in charge of the process of determining how we were going to reorganize the delivery of health services of which they were primarily in charge.

Now it was decided that in order to get at this question of monitoring the quality of care in those institutions and setting the standards, that if that was going to be done, it had to have a strong base of medical staff. So they assigned the responsibility of creating and adopting bylaws for the consortium called the Consortium-affiliated Medical and Dental Staff Bylaws which was a section within each of the

individual hospital's medical and dental staff bylaws, to the staff.

They got that done, and it was signed onto by all of those nine hospitals and their medical staffs, an incredible thing, and the bylaws of the medical and dental staff of the consortium are two small pages long. If hospital administrators had written this, it would have been 3000 pages long, because I would have wanted to have every exception possible to protect the interests of the institution. But they were advised by a very sharp young guy, as a legal counsel, and used their own good judgment. The strength of those bylaws, particularly their power and impact, rests in their simplicity. The strengths are in three areas.

One is they said each physician must have a primary hospital appointment in one of these hospitals, and that if he lost that primary hospital appointment in any one of those, he automatically lost it in any of the others in which he was a member since that was a requirement that he have a primary hospital appointment. Second, that implicit in this and explicit was that if you were on the staff of the Manchester Hospital as your primary appointment and wished to apply for four of those other hospitals on the consortium staff, they would bypass the usual and customary credentials committee rigmarole and appoint you directly on application.

That is of enormous significance because of its precedent, as you can imagine. It said that Hartford Hospital regarded all the other institutions' credentials committees to be of equal competence to theirs, and that opened the way to what for years we have been stymied over, and that is the inability to accept another institution's or other physicians' diagnostic resources as of equal competence, and a whole host of issues of accepting the other institution as of equal competence.

They kept the integrity and sovereignty of the individual hospital's bylaws intact, and each respected the other, since they wanted to have their own bylaws kept intact. So if they had certain kinds of rules, and you admitted over there, you followed those rules, even though those same rules didn't apply here. That really is the essence of the medical staff bylaws structure. It is that simple and workable.

Next, they sat down to look at the question of the decision-making process. They knew that the hospitals would tend to lose their walls as a result

of the newly formed consortium, and that this would tend to make them a melting pot which makes stew. They would all come up with some publicly acceptable standard of blandness that would destroy them as discrete institutions and viable hospitals. Therefore, they decided that as a major policy, they would protect each other's integrity and sovereignty. There was no reason why this couldn't be a mosaic made up of a variety of separate entities, that retained their character, color and identity; but which, when they were put together, said something. There was nothing wrong with them being independent and distinct, viable entities, as long as they said something when they were put together.

Second, they realized that in every way possible the hospital needed to be secure. That insecure institutions, like insecure people, take; they don't give. If the theory was going to be that the strength of the consortium was in the strength of the individual institutions, then it was incumbent upon each of the members to worry about the other, so that the other didn't get insecure when something happened to it. If you dealt with issues like combining clinical services, you first look at whether it would cripple anybody in the consortium. What would it do to the institutions in terms of their viability?

Now this was a novel idea to them because they realized that the consortium need not cripple one member by sacrificing its strengths in favor of the weaknesses of another, or that any one thing had to be in one place, and I don't have time to go through some examples of that, but I think it is self-evident.

The idea is that duplication may be in the public interest, but not redundancy. It may be in the public interest to have more of something than less of something, if the issue was maldistribution and access. That was a public policy, and we represented the public and the public's need for help, and thought that we didn't need to apologize for that.

Now third, it was essential that the hospitals regarded themselves as spokes in a wheel, and that it was necessary that they regard each other of equal competence, different, but of equal competence, so that sameness wasn't going to destroy them. If they were going to do some things together, it was very important that they regarded each other as being different. It wasn't all that difficult for

them to regard themselves as different because when I went around to visit them the first time, and once alone with each individual hospital administrator, the first thing out of their mouth was, "You have got to understand now, John, we are different." If they are different, you can bring them to the table of equal competence.

A very mundane example. You are going to build a house, and you are a carpenter, and you are a plumber, and I am an electrician. We are not going to have any problem if I am younger, less educated, less experienced than you, as long as I am doing the electrical work, and I am not messing around with your plumbing. The problem is if both of us are plumbers. No way I am going to regard you as of equal competence. You are younger, you have less gray hair. You don't wear the right suits, anything: age, sex. It will drive you right up a wall in a consortium if you deal with the issue of sameness. So we concentrated on the idea that each of these institutions was going to be an individual entity responsible for a piece of the action in a targeted population.

We have a unique advantage. If you blew them up, and with good planning, you would put them right back where they are. So we don't have a tough problem with geographic dispersion.

The question was: What do you mean by autonomy and independence in a sharing relationship? The idea was that the Hartford Hospital has a piece of autonomy and responsibility. It is clearly theirs and belongs to nobody else. The only place where they share and commit is there. It is that piece of the action of sharing that ought not to destroy it. So we set about to say: How can we make decisions? The original idea was that they would all vote.

Now voting on an issue of everything over \$25,000 in new equipment or all new programs, which was built into the bylaws, meant that you couldn't have a VA Hospital on board, and even though they signed on in the beginning, they illegally signed on, neither could you have a university state-owned hospital because the state, like the Federal Government, cannot by law abrogate its responsibility for resource development and program to a private corporation. Even in the beginning, one of their members had its right to sovereignty and autonomy, even though he paid dues, while the others did not.

If each one of them were going to be different, then you couldn't vote. You voted with everybody being different and an expert in their own area. St. Francis was to know more about what was appropriate for St. Francis. If you put these people together to make a judgment on the resources and requirements for viability of St. Francis Hospital, do you know what would happen? She would never put anything on the table. Zero. She would package it, put it in the bowl, get everybody on board she could before the meeting and challenge anybody to knock her down, or they would decide nothing.

We sat down to figure out how you could make decisions if you weren't going to vote. It was decided that we had to vote on issues that have to do with process and recognize that we had to make decisions around what I call developing structure and function, deciding the process by which their conduct would be ruled. You could vote on these bylaws very easily because you were discussing process, but you weren't discussing resources and programs.

So they do vote, but they don't vote on the issues of program and resource allocation. They make those decisions by consensus. Essentially, the same rules apply to consensus as they do to vote. If St. Francis wanted to buy a \$250,000 piece of equipment, they had to lay it on the table, and bring this group to a consensus before they would vote. I explained that to the VA Medical Director in Washington when he said he couldn't join. He said, "I could join that one, because there is a difference between laying it on the table and agreeing not to do something until you reached consensus as against their ability to vote you up or down."

Now one can put anything on the table one wants; take it off; put it back on; change it without threat, but it is agreed that they will not make a decision until we can get the consensus two times that that wasn't going to work. What if you didn't have time to reach consensus? On that basis we decided who was the best and most likely to be right in a decision like that, since if you voted, the majority is more likely to be wrong than right, or at least you have increased the margin of error.

If your ceilings fell down, as they did at the

Institute of Living, you can't wait for a month to bring the group to consensus and talk about whether you ought to fix the ceilings at a cost of \$345,000. You fix it. What you can do, after taking that action, is bring the group together and bring them to consensus retrospectively. In that case it tended to inform the rest of the group.

The second time it wouldn't work is if St. Francis was doing heart surgery and Hartford was doing heart surgery, and the comprehensive health planning people said, "There should be only one heart surgery in town." You can talk for a thousand years, but, Hamilton had his heels dug in, Sister had her heels dug in. You had to make a consortium decision. What do you do then?

I gave them several options. One was that since I loved them all the same, and I had prejudice toward none, I would decide, and they went boo.

I said, "Well, let's give it to the trustee members." The legal trustee members that represented, the lay trustees, and the lay trustees said, "Don't do that to us. We don't know anything about it. We run ball bearing factories and insurance companies." I said, "Well, let's give it to the health department. Let them decide. They love that." And they said, "You have got to be kidding."

So I said, "Well, you haven't any options left except to hire a couple of management consultants. Then you would have to pay them a million dollars because you would throw their report away." That is when you vote.

Now the success or failure of this consortium is going to be dependent on the least number of times it votes. When we got to that hard issue, and we put that to these two hospitals, Hamilton said an interesting thing. "Before I am going to let these guys vote our fate, that will drive Sister and me to consensus."

They divided up the management of this into three councils, a Council of Hospital Administrators, a Council of the Lay Trustees and a Council of the Representative Doctors from the individual hospitals. Each hospital has three members that sit on that Board. The idea was the doctor was going to be able to represent all the doctors. That didn't fly, and you know that wouldn't fly. One of the doctors was a neurosurgeon, and you get on the subject of obstetrics, and he is not believable.

So the obstetricians say, "What are you talking about? Dunsmore is a neurosurgeon," and that was

going to be really bad, so we decided why not keep the same philosophy? If it was right that you respected the expertise of each hospital, why not respect the expertise of what is in the consortium on all levels of expertise, and put together advisory committees and force the issue of obstetrical beds right down on the chairmen of the Department of Obstetrics, and see what they do?

Well, I can tell you I would start it with that one because when I got them together at the meeting, I said, "It is up to you to decide how we are going to deal with the obstetrical beds."

They said, "No, no. We can't even agree on the time of day. We never have been able to."

I started to get up and walk out of the room, and I said, "It is okay with me. Then I will tell you what is going to happen. Somebody else is going to decide, and that is not just some threat. I have got all the horses. I can give it away. They are waiting to do it."

It is amazing what these guys will do because they know something about peer review, and they learned it when they were medical students. They are tougher on each other by far than you ever would dare to be. So they advised the professional staff council on all matters like that, and this idea that I keep hearing, even some of our own guys say that the reorganization of the health care system is too important to be left up to doctors and health professionals is nonsense. It had better be left up to us, and we had better do it in a responsible way.

There are few organizations that are more susceptible to conflict than a consortium. It really deals with the four loyalties: the loyalty to the hospital, the loyalty to the profession and ethic that is involved, if this is a largely medical consortium, the loyalty to the patient in the community, and the loyalty to the newly created consortium.

You know, I don't want a group of disloyal people on my Board. I think that the key to all of this is to make sure that the loyalty that is demanded for the consortium is not in conflict with the other three. I think as a hospital administrator I remembered that when you are dealing with doctors and other professional people, that your institutional requirement for loyalty ought not to force them to that position.

The consortium then was really put together to get us back in charge, so that we could, out in the

open and believably, really get at safety determination in the public interest.

What we didn't realize was that if you have all the hospitals in town, there is no health problem you can opt out of, because they can't say at St. Francis, "We don't do that, Hartford does that." So the blacks knock at your door, and you say, "We really haven't got to address that," but they say, "You are the only store in town." So all of a sudden, general, acute episodic illness oriented institutions are in

health maintenance, health prevention, transportation, alcoholism. You name it, we are in it; including a visit from the rape group who wanted to know what I was going to do about the rapes in town. I wasn't too sure what she was talking about, but I made the dumb statement that I was going to help.

Thank you very much.

Mobilization for Survival: II. Intrahospital Approaches

SAMUEL J. TIBBITTS

CHAIRMAN SPAETH: Our next speakers will be speaking about the Intrahospital Approach.

Our first speaker in this regard is Sam Tibbitts, Lutheran Hospital Society of Southern California in Los Angeles.

MR. SAMUEL J. TIBBITTS: Thank you. I don't want to break the string here. I think I probably would have been more qualified to speak on multiple hospital systems, mainly because I haven't run a hospital in ten years. I will do my best, though.

I actually think that the climate is right for hospital administrators, trustees and doctors to get together a little bit now. It has been a little bit difficult in the past, but I think at least we have one little common denominator. That is, all three are extremely nervous which means there may be some opportunity to move them in the right direction.

It seems obvious that the individual hospital has to do something since the government is moving in and the financial crunch is certainly there. Right now every hospital can't join a multiple hospital system and possibly doesn't want to, but certainly that individual hospital has to do something, and to me, that something is planning.

I have always been a believer in planning, but having been through our doctors' slow down in California in January, I have now become a very firm believer in planning. If we had not properly planned for that slow down several months before it occurred, we would have been in rather severe financial trouble.

As it turned out, we own three hospitals and manage five others in our multiple hospital system. Only one hospital during January, even though we had drops in occupancy up to 50%, operated in the red. The others developed a bottom line of anywhere from two to six percent, and we managed to hold cash flow position in a very reasonable fashion. That proved to me, if you properly plan, you can meet most any condition, at least, on a temporary basis.

I think, as you know, the planning for evolution of hospitals as viable institutions capable of shifting their community role in response to government controls, changing conditions and service demands, requires a unity of purpose on the part of management, trustees and medical staff. This is often illusionary and frustrating. However, such a consensus is imperative if the institution is to concentrate its efforts on reaching clearly defined goals and avoiding the common pitfall of vigorously pursuing objectives which in retrospect proved to be contradictory or even mutually exclusive.

Consensus can only be achieved through active involvement of management, medical staff and board throughout the entire planning process. Each participant must be given an opportunity to express his considered judgment regarding the nature and scope of services to be offered by the institution, be apprised of the views held by other participants and be exposed to those external and internal limitations which somehow restrict the range of available options.

From this, compromises can then be reached, differences reconciled and a plan produced which represents a consensus of aspirations which have been tempered by the constraints of financial feasibility.

In short, the hospital must develop a strong commitment to continuous self-evaluation in the light of changing conditions, and this type of internal assessment cannot be effective in the absence of the active involvement of the key participants.

Now to achieve the active involvement of the triad of key parties: management, trustees and physicians, I believe it essential that a sound and continuous process needs to be developed, introduced and maintained within the institution. This is a process which is exercised within a framework made possible by a commitment to a set of basic principles. Now let me review briefly the principles or beliefs.

First, there must be a well defined plan of action which embraces clearly defined goals and levels of expectations, a systematic approach toward obtain-

ing these goals and a determination of individuals who will participate in terms of a specified time frame and a degree of responsibility.

The process which this principle embraces is one which is organized and formalized to the extent necessary to serve the purposes of the following: sharing the thoughts and ideas of all parties, management and employees alike, about goals and objectives. Having these thoughts and ideas considered, making sure they know the goals that are ultimately agreed upon, and then gaining their commitment to the goals.

Now in our organizational system, we have recommended to our hospitals that they create a planning committee to oversee the workings of this institutional goal setting process. This is a committee whose membership should include the executive director of the hospital, members of the administrative staff, medical staff representatives and trustees, of course, and other selected key department heads, if desired.

It is this group that studies, analyzes and makes recommendations pertaining to major policy matters for the future direction of the hospital. Second, in each area of interest, there must be trustee, medical staff leadership and administrative involvement.

Now as an example of how one of our hospitals has moved toward involving the medical staff in their planning and goal setting process, this hospital has recently established a planning and evaluation committee of the medical staff. This committee composed of active members of the attending medical staff with broad representation from each clinical section has as its purpose the task of determining in the form of recommendations through the Executive Medical Board, short-range—which by that I mean one year and intermediate range, five-year goals and objectives of clinical services based on the needs of the attending medical staff. It also fulfills the function of evaluating whether approved goals and objectives were achieved to the reasonable satisfaction of the attending medical staff.

Third, there must be close coordination and good communication among those participants exploring the various areas since fruitful results are dependent upon successfully integrating the overlapping and supportive items of interrelated areas of interest. Now it is in this phase of planning dur-

ing which departmental objectives are developed.

It is important that the process accommodate at more than one point the need for identifying horizontally related objectives and determining appropriate approaches to insuring balanced integration of these objectives.

The objective-setting process in our hospitals requires documentation in a specific format of each objective committed for achievement. This type of documentation assists department managers and administrative executives in identifying functional areas of the hospital having interrelated objectives, and in thinking through the course of actions required to attain over-all integration and in specifying the degree of responsibility, each involved manager will be held accountable for.

Fourth, all participants must be properly oriented to the new environment which faces hospitals through a carefully planned factual program which clearly delineates the external controls which hospitals will be coping with. Of course, this moves way up in the process and is one of the first things that should be done. This is extremely important since if we cannot produce a climate in which the participants can approach problems from a cold objective point of view, the value of the process naturally will be watered down considerably. Pride, loyalty and competitive spirit are very important to every institution, but if emotion is allowed to overrule businesslike objective decision-making there can only be trouble in the future.

I realize that the proper attitudinal base will be difficult to establish for some people, but it seems to me that the most interested and dedicated persons will understand the seriousness of the situation they face and that they will respond properly assuming that they have been properly educated. If certain individuals place politics, personal gain and personal aggrandizement above the welfare of the institution, they should be dismissed from future activity.

As a means of orienting managers at all levels to the environment, hospitals in our system begin making their planning process and communicating a "statement of conditions," which identifies both external and internal conditions considered to have significant impact either actual or potential, on their

goal-and objective-setting efforts. This document is discussed among managers with additional contributions to its content being encouraged at all levels of the organization.

Fifth. There also is the need for an ongoing organized effort to extend managerial competencies in order to ensure meaningful contributions to institutional outcomes. As indicated in my comments about the planning process, the total managerial staff of the hospital must be involved. This, then requires an integrated performance evaluation process directed toward developing managers based on their individual needs to fulfill objectives to which they have committed themselves.

Sixth. Finally it is absolutely essential that good staff support be provided for this entire activity. This is expensive, but I think it is absolutely essential that it be done. If it is not available within the institution, it should be employed from the outside.

So I have briefly discussed planning as a continuous, ongoing self-examining management process. It is certainly only an overview, but I would like to move now to planning in the institution in terms of finances. This surely is an area of highest priority. As already stated, there will be in the new environment, a very close scrutiny of costs and charges. Thus, the hospital is faced with the problem of carefully analyzing itself with regard to its own individual financial needs and with regard to how its data compare with the so-called peer group of hospitals.

In the new environment, the outside regulatory agencies will place the squeeze on the inefficient, as we have heard, and cash flow will become even more of a problem than it is now. Furthermore, the ability of the hospital to develop a reasonable bottom line, geared to today's expectations, will be diminished, anyway, even be extinct.

In general, financial planning takes place in three areas. They are:

1. Cost containment and productivity.
2. Volume and revenue generation.
3. Prudent use and preservation of capital.

Financial planning, as I have said, is a tremendously big subject so I can only address some basic questions which I think should be answered by each institution and which, I hope, will stir up some thoughtful processes by trustees, administrators and medical staff leaders.

In asking the following questions, I use the word

"we" because I do believe that, again, trustees, management and medical staff leadership have to be involved in this financial planning process.

First, cost containment and productivity.

Do we have in our hospital a viable management with objectives process which follows the broad purposes and policies of the Board of Trustees? Is our budgeting process built upon management with objectives, involving managers at all levels? Is it carefully done and are our projections within reasonable degrees of accuracy? Do we reward managers through an objective evaluative process for reaching their goals? Does this process also move managers on an objective basis to higher levels of competency and performance?

Do we have accurate historical data upon which to project volume, cost and revenue?

Do we know future trends in inflation by class of expense, manpower, materials, utilities, malpractice insurance et cetera?

Do we have cash flow budgeting based upon projected inflation, usage, lag time in accounts receivable, and cash outlay for capital requirements?

Do we have management engineering standards for productivity of personnel?

Are the control and informational systems we use appropriate to produce efficiency and also to inform us of trends on a timely basis? Whether they be favorable trends or unfavorable?

Are our department heads qualified in terms of their skills to administer a strong quality and cost containment program? If not, do we have a good ongoing management training program available for them? If they cannot learn and are not qualified, are we prepared to make the necessary changes quickly?

Do we have ways of determining unit costs of operations, and do we know how they compare with comparable services in peer institutions? If comparisons are not favorable, do we have the expertise available in the hospital to make the necessary corrections? If not, are we prepared to engage qualified outside help?

If after careful study, we find that an outside shared services group, commercial vendor or management firm can do a better job than we can, are we willing to swallow our pride, engage them and get on with the show?

If we do engage outside help, are we prepared, in an objective manner, to choose the best, based

upon carefully drawn specifications rather than the "who knows whom" system?

Are we sufficiently innovative and open-minded to work with other institutions to establish shared services programs which would benefit all?

Can we convince the medical staff, the department heads and others that standardization of supplies, forms and so forth, while maintaining quality of products through properly drawn specifications, will be of cost benefit and should be implemented?

Are our personnel policies up to date to avoid liabilities and loss through problems with OSHA, ERISA, affirmative action, unemployment compensation, and Workmen's Compensation, et cetera? If not, how do we correct and are we willing to accept help and expend money for expertise in this area?

There are many, many other questions we could ask, but let me take a look at volume and revenue generation.

First, has our utilization review group told us what the impact of strict UR controls will do to inpatient volume and outpatient volume, and can we project this somewhat accurately?

Do we have a qualified, ongoing financial analysis program and a contingency plan to enable us to adjust quickly to changes and to plan programs to maximize profitability?

Do we have qualified, ongoing reimbursement review programs to maximize reimbursement for government agencies and other cost reimbursers?

Are we prepared to explore fully the potential of outpatient care trends in terms of revenue generation, for example primary care clinics, medical office buildings and so forth?

Are we prepared to explore possible profit-making ventures with other health entities, such as centralized purchasing, computer centers, print shops, collection agencies, laundries and so forth?

If financially feasible, are we prepared to use this type of vehicle as a means of generating revenue for the tightly controlled capital situation for hospitals of the future?

Are we prepared to explore the long-term benefits of deferred giving and life income annuity trusts for generating hospital capital revenue?

Here again, there are many more questions that could be asked. However, it appears to me that the real question is: Are we willing now, while we have the time, maybe we don't have the time in New York, but I think some of the rest of us do. We still have time before these controls are so stringent that we cannot move freely. Should we spend the money to provide ourselves with a true examination of our current condition and what our future operations should be?

While it will take money and manpower and hard work to do the proper examination of the hospital, it appears to me that this effort is mandatory for the future well-being and the continued viability of the institution.

The tools and skills to properly analyze all operations in the hospital are available. Admittedly at this time, some would be judgmental, but many can be completely objective.

Again to summarize, I think we must first ask ourselves if we are willing to be objective and establish goals and carry them through within a given time frame.

Are we willing to look beyond our hospital to let others assist us or even carry out services if they can do a better job?

Are we willing to explore and implement joint effort activities, whether this means merger, coordinating councils, total management agreements or even new corporations?

Are we willing to explore innovative methods of health delivery and implement them if they are feasible?

And lastly, are we willing, if the self-examination and the trends spell out continual deterioration of the hospital, to convert this institution to some other health delivery service through merger or sale or, finally, to even plan its gradual demise?

I think if we can answer these questions coldly, objectively, and it is going to be tough, then I would say we are ready for this great brave new world that we are now facing.

Mobilization for Survival: II. Intrahospital Approaches

GERALD W. MUNGERSON

CHAIRMAN SPAETH: Continuing on the Intrahospital Approach, our third and last speaker of the afternoon is Mr. Gerald Mungerson, Executive Director, Illinois Masonic Medical Center.

MR. GERALD W. MUNGERSON: Thank you, Ron. Talking about strategy, one of the early strategies that I had to address was how to approach this paper being last on the day, and I had great empathy with Dave's earlier comment about following Odin. I sat there and I said, "There are really probably three things that I can do. One is to stay away and not come in at all until it was my turn to talk and be blissfully ignorant of what had been said before me." I discarded that.

Second, was to sit there and attempt to frantically rewrite what I had already prepared, and I discarded that and settled on the third and last option which was to sit there and suffer through the day and hear everything said that you had planned to say but resolve that you are going ahead and give your comments anyway hoping that it all makes some sense and that your audience will be relatively sympathetic. It is this option that I have chosen.

It was Jim Hague attending one of the earlier symposia who is reported to have leaned over to a colleague next to him and said, "I don't understand much of what is being said. But my dad sure would be proud to know that I'm even here," and that is a true story.

As I looked at the program and found two former teachers—Odin Anderson and Irv Wilmot (both of whom may deny it, but they were) and my preceptor and first and ever boss, John Danielson, and Dave Kinzer, the Executive Director of the Illinois Hospital Association at the time that I entered the field at Evanston Hospital, I must admit I got a little of that same feeling. I am not sure of what more I can offer, particularly after so many splendid talks preceding mine, but I am sure proud of the company I'm in.

Since survival is our subject, I did the obvious

and went to the dictionary to look for some early clues.

Among the definitions of the word "survival" I found the following:

"To live or exist longer than—to outlive or to continue to live after, or in spite of."

I think you'll agree with me that there is a certain element of inevitability in those definitions that I hope we are not yet willing to accept. At least I am thinking in more permanent terms than those definitions seem to imply.

In addition to a definition of the term I think it is fair to ask "survival from what?" Our careers could conjure up all sorts of adversaries ranging from an unreasonable medical staff to an unrelenting community, and all imaginable hazards in between. But for purposes of this paper, I have assumed we are talking about surviving two factors: The encroaching governmental dictation of a voluntary private system and the concomitant governmental thrust to retard our growth and use.

You don't need any more proof that those are the factors than what was discussed earlier in the day, but again for purposes of this paper, listen and reflect on the following:

Medicare routine per diem ceilings being reduced from the 90 to the 80 percent level, 92-603, 93-641, PSROs, and most recently a one billion dollar Medicare budget cut was proposed in Congress.

I think it is also fair to ask just what entity it is that we are worried about surviving. Again you know the answer to that question as well as I do, but let me at least take the prerogative of putting us on common ground and say that it is the hospital, or hospital systems, as a private corporation, responsible for its own destiny, that I believe we are discussing.

It is also a system rooted deep into the history of this country, the voluntary system that I am thinking of; and it is also a system of private financing. Even though the public share, of course, has escalated rapidly in the last decade, health care

is still privately financed even considering the Medicare portion of our public funds.

I believe it is also fair to ask, as undoubtedly many of you are, should we survive? It would be suicidal, or at least masochistic, of me to suggest, to this audience at least, that we shouldn't and indeed the answer is obvious.

But there are a couple of less than obvious elements at risk. First, of course, is the typically American trustee or voluntary system. Some of you will argue that the proprietary system is just as responsive to the patient as the nonprofit voluntary one because it too must please the client whether he be a patient or a doctor in order to profit.

But both or either are better than a ponderous and oftentimes capricious government immune from the direct pressure of the patient and irresistible to the pressure of the politician.

A less obvious risk, but equally important, I believe, is the potential loss of what, for want of a better phrase, I will call private investment capital.

Whether it be CAT scanners, SMAC units or contract services, I believe it has been the relatively independent hospital market, free to make its own choices that has contributed to the rapid technological growth that in turn has contributed so heavily to the quality of American medicine.

I believe the United States, indeed the world, would be worse off without that incentive.

My assignment after all was to help set the stage for some of the presentations tomorrow morning by outlining generically, as Joel is fond of saying, those things an individual hospital must be doing in order to survive.

I can't resist the opportunity—I think I should do so anyway—to list, at least, and discuss momentarily those forces that seem to be pressing on the typical inner-city teaching hospital.

First among them is the increasing militancy among our colleagues in health, the physicians, and that was alluded to earlier.

They cut their militant teeth a year ago on the ill-fated utilization review regulations and are currently sharpening them on malpractice and undoubtedly will get their permanent molars on 93-641. Who knows when they will be extracted or by whom, or even if, but that they are becoming more organized and aggressive is obvious.

Listen to this letter from a physician as quoted by Jack Mabley, hardly a certifiable academic

source, but nonetheless influential and widely read, and I quote:

"What the newspapers do not understand is the present frame of mind of physicians in private practice. We are inundated with paper work from the Federal Government and threatened with more controls which we have to explain to bewildered Medicare patients.

"The AMA is demanding that we attend more meetings to keep up with current advances.

"Academic physicians who do not see frightened parents whose child's appendix is threatening to rupture are writing articles that unnecessary appendectomies are being done. Hospitals are assigning us to committees which debate every issue from parking lots to surgical indications.

"Lawyers who have advised appeasement settlement of every nuisance lawsuit for years, are now telling us that it's our own incompetence which has caused the malpractice crisis.

"The community wants us to go to Rotary Meetings and advise the health officer. The IRS tells every one that we go on tropical vacations under the guise of attending medical seminars.

"I don't think the public knows how demoralized the conscientious physician has become. Unions for physicians are a reality."

A second force beginning to press upon the typical inner-city hospital is originating from its own trustees who, I believe, may be trying to solve industry-wide problems by acts at the individual hospital level.

For example, at our hospital recently there was more than the average discussion over whether we should borrow against the written pledge of a donor in order to accelerate a remodeling project. The argument raised was the increased cost to the public if we borrowed, which exposed to me where at least some of our trustees—fortunately not all—were coming from.

In this case their perspective was not what was best for Illinois Masonic Medical Center, but could we better contribute to society by saying "no."

I am told by friends in Blue Cross—and in Illinois and Chicago at least, we still have them—that General Motors executives have been ordered to get out and get on hospital boards and do something about hospitals and their costs.

This, I believe, if widespread, is a significant change in trustee attitudes that poses an entirely different set of problems for us.

A third and obvious force pressing upon many of us is literally the vise of federal, state and local

governmental fiscal problems. Those of us so located as to place us in the position of serving the indigent publicly financed patient tend to be those with the highest cost for all kinds of reasons well known to you.

We tend to provide most of the care to the publicly financed patient, e.g. in Chicago 13 hospitals provide 70% of the care to the public aid patients in the City of Chicago and 70% of the public aid dollar in the State of Illinois is in Chicago. Yet when a fiscal crisis arises, as you've heard earlier, it is precisely these hospitals that are caught in the vise. One side of the vise restricting payment, the other demanding care.

Well, after that long preamble, I come to my assignment which was to identify those strategies a hospital can use to assure institutional survival.

Unlike most of my predecessors, my perspective is that of a single medical center, not a chain or a consortium or a merger. I guess the most important fact for us to realize is that the issue is survival, not growth for growth's sake, or service for pride's sake, but growth and service for the sake of survival.

Some time ago I was struck by one of Robert W. Cunningham's many astute observations of our field. This time he was addressing himself to the issue of HMOs and why they, at that point in time, had not consumed the health market as so many experts had predicted. He poignantly and I believe correctly stated: "HMOs would not grow without the two necessary ingredients—doctors and patients; and until HMOs caught the fancy of doctors and patients they would limp along."

I believe there is good advice in that observation. Like HMOs, those of us in health care management must remember that we can't do very much without doctors and patients, and whatever we plan, we must keep that thought foremost in our minds.

We should assess our institutional strengths honestly and in so doing, remember Cunningham's observations. Hospital programs cannot be strong without identifiable medical involvement or without patient acceptance. Obviously the process of assessing institutional strength can't be done in splendid isolation no matter how competent your management team may be.

A technique we have used successfully and no doubt so have many of you, is a one-day retreat involving trustees, key physicians and management. The purpose of this has been to try and step back

and take a critical and objective look at ourselves.

It has done two things for us: Brought about a consensus on issues and given us the opportunity to know each other a little better.

Once strengths have been identified, the task is obviously to build upon them, remembering again that no matter how good your management, without physician interest nor patient acceptance, it won't fly.

The process of identifying your strengths will probably automatically do the opposite and that is to list your weaknesses. Again try to be realistic, remembering that in survival, it is the financial bottom line that may ultimately be the test. Can you ever rebuild the obstetrics program or pediatric program? I think there is a tendency among all good managers or at least confident ones, to think that we can solve problems, but in the long run, it may be better for the institution to be rid of its problems. Make that hard decision rather than satisfy our management egos by trying to solve them.

Another strategy for survival, I believe, is to look for a financial release valve that can ease some of the financial burdens that we are facing and that undoubtedly will intensify. Such things as an apartment building, an office building, a nursing home, parking facility as alluded to by Sam Tibbitts can help. Obviously, you must be sure you are not jeopardizing your charter and your primary job and I'm sure you will need some creative accounting to help you in this.

You will need to know your marketplace before tackling this idea. You can't force an apartment building into an already over-built area, for example, or a nursing home into a community where there are already enough.

I believe the name of the game for survival these days is to get out and market, sell, recruit, hustle for doctors and patients.

Returning to Cunningham's admonition one last time, you must have the doctors and patients to make anything medical go.

Don't shy away from the courts. Some of you have had more experience with this than I, but bear with me and let me illustrate the point.

Last fall our now lame-duck Governor decided to solve our State's cash flow problem by freezing Medicaid rates and creating a Rate Review Board to establish new rates.

It was a step designed to penalize the high cost

teaching hospital which the Governor felt was ripping off the system. An attempt to reason with the Governor failed and ours was not a pleasant session, as Dave Kinzer alluded to.

We were forced to go to court to seek an injunction to stop him from implementing the program. The case has not been tried yet. We lost our bid for a temporary restraining order, but by going to court, we have done two things: Stopped the Rate Review Board from issuing rates of payment that are below our current rates of payment, and let the bureaucrats know that we are willing to go all the way to fight for what we believe is fair.

Incidentally, we received good support from the physicians in this case and we have returned the favor by trying to help the physician in his fights wherever we can.

Most noticeably is their fight, and ours, to obtain some relief from the seemingly endless malpractice problem.

In Illinois, hospitals and physicians worked hard and collaboratively to secure the passage of a State Malpractice Law that, unfortunately, is presently being challenged constitutionally. But the collective pressure on the Legislature did have an impact and that is worth noticing and remembering.

I agree with Dave Kinzer in saying that patients and, in general, the local community can be an ally.

In an urban area it is not always easy to identify your community; but I would guess that it is rare that a hospital doesn't enjoy the affection of its immediate neighbors. Very often they use and know the hospital the best, understand its limitations and strengths.

These neighbors and patients can be a persuasive ally, but they too have political limits, and you should know those. I believe Illinois Masonic Medical Center does an exemplary job in serving its

local Latin community, but in Chicago there are limits to what a Latino minority with an anti-Daley-machine-alderman can do for you.

Keep your trustees and physicians, or at least the key ones, informed. The more they know, the less surprised they will be by unreasonable planning decisions, outrageous new rules and regulations, et cetera.

The more they know the more likely they will be to rise to our side than to the Feds. Incidentally, don't keep the physician and trustee apart. Very often they can tell the story as effectively as the Chief Executive can if they have the proper information.

What does this all add up to? I guess what I have tried to say is that in order to survive, you have to be the best manager of the best health care institution in the area. I think that means to me, at least, two things:

We have to be flexible and ready to adapt to the changing circumstances around us and be ready to take a chance when the risk seems worth the potential pay off.

George Bugbee is known to have said in commenting about the quality of a new program in hospital administration, "You can't teach more than a faculty knows."

Well, I've told you all I know and some of you might say, "That's not much," but George had some pertinent words for that too. He said, "But it's possible for a student to learn more than the faculty teaches."

I hope that has been true today.

Thank you.

DISCUSSION

with John M. Danielson, Samuel J. Tibbitts, Gerald W. Mungerson,
Dave Kinzer, Odin W. Anderson and Irvin Wilmot

MEMBER: I have a question for John Danielson concerning the relation of the consortium to the local planning agency. Do they deal with the consortium, or do they deal with the individual institutions?

MR. DANIELSON: This is going to sound strange. We have five HSAs in Connecticut. We should have two, but we have five. We decided early on when the bill was first talked about, that we had better be sure that we had smart guys talking to smart

guys, not dumb guys telling smart guys what to do.

You are going to have to pay them to get smart guys. We began to develop what we call the partnership with the staff of an HSA. We believed that we have a lot to say about who that agency would be, namely, in our case the B Agency. We began to develop early on ways in which we would operate and work with them.

Now we took the posture that 93-641 never gave them the right to practice medicine nor the license to run a hospital. We still had those two, and that that meant they could tell us what to do, but we would tell them how, where and by whom. We had the doer role, we wanted to exercise the doer role, and that would be the partnership.

We began to work out what the partnership might be, not to control the HSA Board, because you couldn't do that anyway, but to establish our role of "doers."

When it turned out that the money that was going to be given to our HSA was less money than the B Agency currently has to operate and that they would have to drop some very good staff people, it appeared that they would be dangerous to us if we didn't maintain their quality. We hit on the idea that we would help them raise money between now and July 1, after which time we can't give them any money. Help them raise money, so that we can have a war chest of dollars going in that is matched 40 cents on every dollar by the Federal Government. It gives them an operating budget to start with that in their first year or two at least keeps their staffing structure.

We believe it was in our best interest to help them do that. Essentially they are not beholden to us in any way, but we end up maintaining our end of the partnership.

Does that answer it?

MEMBER: Not completely, John. Do they try to get inside of the structure?

MR. DANIELSON: No. The reason they don't try to get inside the structure is that they review and demand accountability of how we reviewed any item that we dealt with. We had that all open against the minutes of all the meetings. He and I had a meeting maybe once a week to discuss what is going on in those hospitals and what they are doing about developing constraints. We tend to

operate pretty openly with each other, so he doesn't get inside in an official capacity.

MEMBER: How do you get around the question of collusion, in supporting the HSA financially?

MR. DANIELSON: We are not financing it out of the institutions. What I said was we were helping them to raise money within the community, where we have powerful resources through Board members, the insurance companies, and the corporate community where we are helping them to raise money to develop their own war chest. We are not contributing directly, but there is an enormous amount of help if you can understand that.

MEMBER: In this relationship with the teaching medical school operations, are there levels of affiliation as far as the extent to which the school per se or the individual departments of the school might have informal alliances with hospitals other than those in the consortium?

MR. DANIELSON: The autonomy, the right to sovereignty and the necessity to protect the integrity of the university's medical center is as clearly their right as Hartford Hospital's right is to protect their own.

Now if you go in with that thought, you can talk to everybody about who ought to be chief of surgery, but nobody is going to dictate to the dean his ultimate and final responsibility. Nobody in the consortium is going to suggest they can't affiliate elsewhere.

MEMBER: Mr. Kinzer, your last straw concerned the incentive for patient preventive health, self-care or avoiding getting ill. I would really like to invite some of the other panelists to react to that, mainly because it seems like there is going to be more incentive for the patient to take better care of himself. I guess I have only been at five consecutive symposia here, and I have heard preventive health talked about each time, but it is the first time I have ever heard anybody say it was really getting closer.

MR. KINZER: I only half believe my tenth straw. I was trying to say that we have got to do something. It was sort of a desperate statement. I heard the brilliant idea that we penalize the smokers, and

I am one of the people that smoke. Maybe I won't be motivated, but I might be if I have to pay 30 bucks a month more in premium. I don't know.

MR. MUNGERSON: For years there have been some financial incentives in life insurance to do something about personal health habits.

The impact of this has been limited. I guess what I am doing is reinforcing your skepticism of this notion.

MR. ANDERSON: I would like to react to that. As a non-smoker, I am against it on principle. For one thing, I don't think that it is enforceable. I can't see that there are enough ascetics in this country to carry a majority vote, at least on national health insurance, in order to tax the hedonists, because I think most of us are particularly hedonistic. As a humane society, we need to treat both the saints and the sinners equally.

MR. TIBBITTS: Possibly the individual incentive is not the way to go, but I think management, particularly of large companies, is very interested in preventive health. It may be that the incentive goes with management in order to keep their health care premium down. I think we are going to see in the future that some of these large companies will move into preventive health care and into health education in a fairly big way.

MR. ANDERSON: Well, health education is another matter, but to legislate morals, our behavior on that level, I am against in principle. I think it can lead from one thing to another.

MEMBER: In the Health Planning Act, there is a section that deals with allocation of cost, an accounting system and inclusive rates. It will carry its own self and not attach it on to another one. Is that going to force the reentrenchment we have talked about?

MR. MUNGERSON: Let me respond. I am not familiar in detail with what you are talking about, but I have a philosophical approach which is similar to Dave Kinzer's this morning.

I think we have some people in the management

field in hospitals that can beat most any screwball system that comes down the pike, though this may not be a screwball system.

This system is going to force reentrenchment, but only depending on what the rate is, not what the system is. If the rate is reduced, obviously, we are going to have to do something to respond.

MR. KINZER: We have this silly nonsense going on in Massachusetts.

The intent of that section is to forbid you to cross-subsidize on services. Everything has to pay its own way, and what this would do, if they carry it out, is destroy start up on new services. It would make it impossible in many situations to provide services that are essential and will never pay. I just don't think it will ever fly high.

One of the things we are talking about now in Massachusetts is increasing the inpatient subsidy of outpatient to get people to use even more outpatient. I am dubious about that, because we have been subsidizing it for years, and we are up to 80%. We can't afford that, so I just don't think it is going to fly.

MR. DANIELSON: You are opening a door. I wish Irv Wilmot was here because he and I were at a meeting together not too long ago. I asked him about how come with all of this crying "wolf," and how they were all going down the tube, he always ended up at New York University Hospital in the black. He doesn't look like a guy going down the tube to me, nor does the hospital, and he made a very interesting comment.

He said what you do is simply cut back the services based upon what income you have, and produce only those services based on that income. The public ends up either having to accept a level of risk that is morally and economically sound to them, or they overthrow the government. That is, they really start objecting. In the consortium, if you have all the hospitals in the area, all the doctors and all of the health providers except the agencies which we relate to, the question of acceptable level of risk is something that is going to have to be addressed by the community at large in a major public forum.

We are caught over the issue that the public demand seems to be that everybody should die, a clinically blameless death. Nobody really believes that. It is the difference between accepting public demand as if it was something you must do versus sorting out their needs, which is what they expect. We are really on the responding to demand.

I heard Alex McMahon say at the New England Hospital Assembly that the people must stop demanding what they are demanding because our resources can't keep up with demand. I am not sure that they are going to stop demanding. I think it's somebody's responsibility to sort out need.

MR. ANDERSON: Who can determine what need is? Can't the public determine what need is if they want to pay for it?

MR. DANIELSON: No, I don't think the public can or expects that they will sort out need. I think that what they figure is they have paid hundreds of millions of dollars to develop some experts that are supposed to know something about it.

MR. ANDERSON: We are turning into a paternalistic system now. We are turning into a technocratic paternalistic system of telling the public what they should have.

MR. DANIELSON: I think that isn't such a bad idea.

MR. ANDERSON: I do. I am violently opposed to it.

MR. KINZER: I wanted to add a dimension to this. I talked about the example of the 75-year-old lady with the total hip replacement earlier. Before we had Medicare she would not have received it, but now she needs it, and the real dilemma here is that she is on Medicare. Who is going to decide that she can't have it? I said somebody has to decide, but this is really tough. It isn't as simple as you stated.

MR. DANIELSON: What I was saying is that the decision is dependent on how much money they are willing to spend.

MEMBER: Panelists, as long as you are on this

topic, why don't you bring in the third question, not only the public demands, and what the system is able to give, but the government that says, "You give this, but you give it at less than what is optimal in terms of the professional standards that would be established."

For example, drug addiction or alcoholism. A 5-day detoxification is all you can give. It is better not to detoxify the guy than to get him in and not do anything about the psychological values behind his drinking.

MR. TIBBITTS: This is the point I was trying to make. I don't think our problem is with the public. The public still thinks we are pretty good. They think we are meeting their demands for the most part. Harris did a poll for the proprietary hospitals, and it comes out very well for all hospitals and for doctors. Our problem is with the government, and the problem is: How do we provide all these great things that the public wants and the government doesn't want to pay for?

Somehow we must force the government to set up priorities. They have to say, "We are going to spend so much money for indigent care, for alcoholism, for drug detoxification, for what-have-you." The public then has to know that that is all the money that is there, and then possibly the providers of care can be properly reimbursed for the services they provide.

MEMBER: Why don't you finish that story because the Harris poll showed that medicine in general was doing an acceptable job with 42% of the public, and the government was doing an acceptable job with 8% of the public?

MR. TIBBITTS: That is right.

MEMBER: So we have 8 percent trying to tell 42 percent how to do it better.

MR. MUNGERSON: I just had an observation about need determination. You heard Irv Wilmot this morning talk about need determination. It is not being made at the public level in the face of the fiscal crisis. It is being made by Irv Wilmot and by me and by other managers of institutions who are faced with frozen rates and reduced reimbursements. We are making the cuts necessary to live and sur-

vive, and there is no public need determination from my perspective taking place.

MR. ANDERSON: I think one thing we have learned from foreign systems, and particularly Canada, is that the public is not aroused about the rising costs where there are national systems which absorb the cost into the tax structure. It is not a political issue in the public. It is a political issue among politicians, and those raising the taxes. But, the tax crunch for national systems, as far as the public is concerned, has not arrived yet. Somebody has to decide priorities as to where the money should go on the national basis.

MR. DANIELSON: I want to come back a little bit to the question which upsets me. We just keep talking about the Federal Government doing all this stuff to us. It has been my experience that in the case of a hospital trustee, when separate views plague his house, that is, separate advice comes up from professionals, he will turn away from those counselors, and he will go elsewhere to look for advice.

Now if you really honestly stop and think about it, if we don't come to some agreement about what it is that the Federal Government's role ought to be, it seems to me they are going to go for advice elsewhere. That is where they are going because they are listening to four or five different viewpoints.

There are three or four viewpoints at this table, and I am not sure that that is going to be very believable because the public represented by the legislator really needs advice.

MEMBER: I guess it is a combination of a question and a comment. We have tried to make the public an issue as far as concern on health and cost and all the rest in our community, and invariably, if we have a health education series, they show up for arthritis and heart attacks and diabetes with a passion. We have a seminar of spectacular quality, and we never get an audience. The public does not show. The only people sitting in the audience are the staff people or the news media people who are looking for a newspaper article the next day.

Essentially, the public is not concerned, and I think it goes with what is being said. I would have to disagree with Sam Tibbitts' issue about industry

and labor wanting incentive systems. Unless labor wants it in a contract, their incentive right now is to get more; never less. They are not building incentive systems in labor contract negotiations, at least not yet.

Our Blue Cross Plan has offered several incentive systems in hospital care and in dental care. You know, if you have an annual checkup every year, your dental bill is a higher participation. Instead of an 80-20, it goes 85-15, 90-10, if you maintain your annual checkup. Nobody wants to buy that. They don't want to buy it. Most of those contracts are sold as union negotiated arrangements, and they want total coverage. That is all they want.

I guess the issue is the public doesn't want less than full coverage and they don't really care what it costs until government gets in the crunch. I am afraid we are going to end up where Canada is right now. It is going to turn around and say, "The way to resolve that is to close X number of hospitals." We will cut the cost out completely, and then we will have a reduced market. We will let the economic forces control utilization and the actual remaining dollar usage.

Without a Congressional limit on the budget, how are they going to put a cap on it if they are going to deliver more?

MR. TIBBITTS: I have to disagree with you to some extent.

It seems to me management is now saying to labor: That's a bunch of money that we are going to spend for health care. It's yours. You spend it any way you can, but we are not going to give you any more. Now that puts labor on the spot to go out and buy a health program that may force labor to go after socialized medicine or some type of socialized care.

It may also force us into providing labor and government with some alternative to that, and I have to agree with what John said. It is about time that we let government and everybody else know what we think should be done with health care, what we think the priorities are, and then let them hash it over. But we really haven't done anything on that score.

MEMBER: Who is "we"?

MR. TIBBITTS: We, meaning all the people sitting in this room.

MR. ANDERSON: You mean the providers of care?

MR. TIBBITTS: The providers of care along with organized medicine.

MEMBER: I am Len Schrage. I am with the Health and Hospital Planning Council of New York that Irv Wilmot spoke about earlier. Just to amplify a little bit on the so-called crisis in New York City, as you may know, the State Legislature proposed a bill which would result in drastic cuts in the Medicaid program. There were a number of interests in New York City, including the hospital association and our council and others, who felt that this was not the way to do the job. We ought to give some of the legislators some idea as to what we think the priorities are, if we are in a crunch, and we definitely are. For example, New York City Government is cutting back on its local tax levy by over a billion dollars, and a lot of that affects health services. We felt it was important to offer some alternative, such as closing hospitals with the idea that in this kind of a situation, you don't reduce everybody to mediocrity. Some alternative was offered and the Legislature did relent, and of course did compromise.

The situation is tough. For example, in ambulatory care, they were talking about a reduction in reimbursement, and what we get is a freeze. So that I think, based on experience, that it is essential that providers do offer some alternatives when faced with this kind of a situation, a ceiling on public and private dollars in the health field.

MEMBER: Should we, and if so, how do we dispel the politicians from selling comprehensive health care to everyone as a political issue?

MR. KINZER: I tried to say in my talk that we can't at least not this year—it is election time, and nobody is going to be against this, and I am not sure Senator Kennedy is going to change at all in his crusade. I think it will take some time.

Some politicians are shaken on the cost issue sufficiently to have second thoughts about the whole

idea of national health insurance. As Dick Wittrup said everybody should be for and quietly work against health insurance. Perhaps there are more politicians that would just love to keep this up as an issue and not let it pass.

CHAIRMAN SPAETH: Does anybody else on the panel want to comment?

MR. TIBBITTS: In the first phases of national health insurance, I don't think it is going to be comprehensive. Probably the best thing that is going to come out of it is a minimum benefit package plus catastrophic health care. We should discourage totally comprehensive health care on July 1, 1977, mainly on the basis of cost. There is no way we can afford it.

MEMBER: When I was much younger than I am now, I was being pretty aggressive one day in an executive committee meeting. A wise old doctor leaned over and said, "Your problem is you think every problem has a solution." Somebody also said to me the other day that if something was rational, it wouldn't need to be political, and I think that is the point that Odin Anderson was talking about this morning.

If you try to be rational about allocating health services, you end up in absolute absurdity. The only alternative that is left is to grease the squeaky wheel which is what we all do every day anyhow.

One of the things that we have never had articulated, probably because it is a very unpleasant subject, is how health services in fact get rationed. For example, I have a notion that one of the things that is an important factor in rationing health services is the limitation on doctor's time. If the doctor can only see so many patients, then only so many patients can be seen.

You realize that Massachusetts cried because the general relief category was cut back, and you go to Arizona with a large Chicano population and find out that they never had Medicaid to start with. Now there is some kind of an effective rationing system that is going on without any policy, without any blame on government, or whoever it is. It seems to me that one of the things that all of us could benefit from, if it is politically possible to do it, is some better understanding of how the rationing system works.

Dave Kinzer did a good job in Massachusetts of crying gloom and doom all over the state about how everybody was going to be bankrupt when the general relief went off. We had a lot of discussion in our own place, and I said we use the Kentucky system. They said, "What is that?"

I said, "Just make it so damn hard for them to get in that they give up."

The truth of the matter is that I don't know what other hospitals are reporting in Massachusetts, but we had a couple of bad months, and these patients disappeared. I don't know where they went.

MR. WITTRUP: What I am saying is there is an unspoken rationing system, and I have a suspicion that it is the only one that will work.

MR. KINZER: I wanted to ask a question related to informed opinions about appropriate allocation of resources. The classic example of this is what we have done for the old people which is costing a bundle, and there still is abundant documentary evidence that we are doing a lousy job with children and teen-agers.

There are going to be 28 million people over 65 by the turn of the century, I wonder, even if we express the opinion that more money should be spent on kids, will this dissuade them in any way whatsoever about their rights to medical care? Will there be less insistence?

MR. TIBBITTS: No, I don't think it will.

We must come to grips some time with how long we are going to carry these old people on artificial respiration and everything else just to keep them alive. We are going to have to get rather coldly objective. It may be extremely difficult for doctors and hospital administrators to do that, but those are some of the hard decisions that have to be made. We are spending a lot of money that shouldn't be spent on older people just to keep them alive for a couple more months.

A rather interesting thing has happened in California with this malpractice crisis we had and the doctors' slow down. Our occupancies have not gone up to what they were in the previous year. They are still down.

Two things, I think, have happened.

Number one, patients have found out that probably they don't need the doctor as much as they

thought they did, so they are not going to see him. Office practices are also down. Number two, a lot of doctors in California are going uninsured because they don't think they can afford the malpractice premium which means they are not taking the high risk stuff, and they are keeping patients out of the hospitals. That is a devious way of doing what you want to do, maybe. I don't know.

MEMBER: There isn't any other way to do it.

MR. ANDERSON: I don't think providers should arrogate to themselves what they regard as the proper allocation of resources. They don't know anything more about the proper allocation of resources than anybody else. What the providers should do is say: Well, if you want such-and-such, this is what it is going to cost, and here are the possible benefits.

I hope we can educate the body politic sufficiently. If we can't do that, then it is really a mess. But I don't want to see the providers arrogate to themselves what you should have.

MR. WAGNER: Mr. Anderson, I am somewhat interested in the curriculum that you now have for future administrators because I hear today a rather naive understanding of how the political process works, how laws are passed and how public policy is developed.

I wondered to what extent currently you have included in your curriculum courses in government and public policy, the formation of a political opinion. Laws don't get passed because politicians want to pass them, and politicians never create issues. They ride them, and government isn't just some sort of third force that drops down from Mars.

Unfortunately—I guess it is a shame, that we don't feel that government is as representative as it once used to be. It still is somewhat representative, and I think the folks here are kind of kidding themselves on these issues that the public really doesn't care or the public is demanding this or that. So perhaps you could enlighten me as to how you handle this in the curriculum.

MR. ANDERSON: Here is what we have along the

questions you ask. I have a course in public policy and comparative health systems, and I try to show how the various health services have developed in different countries, in different contexts, and what the stages of decision-making have been with regard to certain issues. That has narrowed the alternatives.

But now we also have had with us this last year for the first time, a political scientist, Ted Marmor, who is interested in public policy of health and welfare. We are now teaching our course jointly.

MR. MUNGERSON: I didn't have the benefit of Odin's policy formation, obviously, but I have a little practical political experience that took place in the last year and gave me an awful lesson in futility that maybe somebody can contradict. As I mentioned, we were facing an imposed freeze of Medicaid. Four or five of us were lucky enough to go down and meet with our Governor who is fortunately now a lame-duck. We tried to persuade him. We the providers tried to offer to him other ways in which he could deal with this cash crisis that he was facing.

We talked to him at that time about fraud in the Medicaid program. We knew where the laboratories were that you all had heard or read about and what was taking place. We talked about fraudulent recipients of public aid. We talked about the possibility of helping him decide, or his Cabinet decide, what kinds of benefits to cut selectively to accomplish what we are talking about.

After two hours the answer we got was, "Well, don't talk to me about these problems. There aren't any votes in the Medicaid program. Nobody really cares about the sick." I don't know where you get that kind of political education, but it is a tough one to receive, and it is tough to bounce back again.

MR. ANDERSON: Did he say that there aren't any votes in the Medicaid program?

MR. MUNGERSON: Yes.

MR. ANDERSON: That is real candor. I admire that candor!

MR. DANIELSON: By the way, in a state like Connecticut, Odin, that has been said to me more than

once by a politician because we are second in per capita income and we are something like 46th in per capita expenditure for health. The poor don't elect anybody because we are so rich. I don't think you can generally say that the politician is not responsive to those things.

I think that we are not all that politically naive, Mr. Commissioner. We just run into maybe a different level of the public policy formation, particularly when enormous constraints are on the politicians to do something about cost and so on. But they use—they, being the politicians and the legislators—an unfair tactic on us, a terribly unfair tactic. It's called logic, and they want this whole thing to be logical.

When you try to explain whole pieces of the health care system in terms of logic that the ordinary guy can understand, it is very tough to do.

I think you probably can't organize this nationally. I just simply don't think it is possible for the American Hospital Association, AMA, the ANA and the whoevers to organize with one beautiful unified voice to advise the great body of trustees called the Congress responsible for the health of the people the way they would like. Therefore, it seems incumbent upon us to break it down into small manageable parts. It is important that those representatives that go to Washington from that area have a unified voice. I think if there is anything that these consortia or health systems or multi-institutional systems can do, this is it. I think that is what is implicit in 93-641.

I don't think we are all that politically naive. I think we are responding to people who are asking us to be logical about almost illogical problems.

MEMBER: In talking about survival today, I have heard the concept of a cut-back in services mentioned many times. There has been little talk about cut-back in education which many of our institutions are deeply involved in, or even the impact on education.

I wonder if the panelists would comment on that in the context of survival?

MR. KINZER: Speaking particularly for the teaching hospitals of Boston, they don't even want to talk about it. Whenever you bring up cost control, they skip over that subject. I don't know how we are going to get a handle on that.

Mr. DANIELSON: It goes back to our inability to be able to deal except on single parts.

You must remember that at one time every drug-store ran a medical school. We made a great hero out of Flexner whose single, clear message was: If you educate fewer doctors, you are going to have better doctors, and therefore, the health care of the people is going to improve.

It wasn't until a number of years later that the great accusation, now cyclic again, was: It's the doctor that is keeping the young guys out of going to medical school who ought to go to medical school. If we had more doctors, everybody would be taken care of better.

Now you pump those medical schools up, so that coming out of the tube now are going to be a whole host of doctors, more doctors than we need, and we are now being told by the Federal Government through the Kennedy's legislation that we have got to restrict the number of doctors, and certainly the number of specialists. What I am suggesting is that we are always behind the public policy; public policy being whatever the popular political demands are.

I think that there are some issues right now about cutting the cost or sharing the cost of education of house officers. When they were paid \$25 a month, room, board, laundry and all they could steal, nobody cared how many of them you had. But that price tag right now is over a billion dollars, and it's piggy-backed right up on the patient care. Not one nickel of it is paid for by the partnership, the partnership of the practicing profession where these guys actually do the work. These fellows keep them in private practice because the practice of medicine has moved into the hospitals, and that is where their partners are.

We can come to grips with some sort of a sharing relationship of that kind of costing structure, where a third of that is on the partnership right off the feed pool, a third of it is on the basis of care and organization of the hospital, and a third of it is off an educational front-end funding that is reasonable. But, nobody comes up with a reasonable and logical way to do it. They wait until the Kennedy Bill or somebody outside the system tries to make logic out of our illogical system.

If we really begin to talk about getting angry about the survival question and not having enough money to survive, we begin to lose probably the most important image that is going to keep us in the public heart. The hospitals have always had an image of compassion. It is the role of the institution, and if the institution can't fall in love with their communities, be they bad, dangerous and tough, nobody is going to. We are never going to get the support of the people.

Even in this room we are becoming angry, angry at the poor people, and okay, we won't serve them. Make it tough for them to get in. Where do they go? I don't know. We have to be careful that we don't lose compassion. Because if we lose compassion, we have lost it all.

I am not so sure but what we may be in a cyclic relationship both in terms of education and in terms of service, and that is that the "Robin Hood" theory was not all that bad.

CHAIRMAN SPAETH: John, what is the "Robin Hood" theory?

Mr. DANIELSON: The rich pay for the poor.

Mr. MUNGERSON: I was going to address myself a little more specifically to the education question.

The physicians just don't like to talk about it. They begin to talk about it when you lay out the choices and say to them, "If your choice is two or three less house staff next year or the inability to serve in the laboratory the patients on a 24-hour basis," they begin to come around.

We were faced with this last year at Illinois Masonic, and we were successful in getting the physicians to reluctantly agree to eliminate 10 to 12 of the house staff positions prospectively. You don't release them right away, but prospectively, off the rolls.

There are some mitigating factors with that, but if you involve them in the decision process, sometimes they come around and say, "Yes, we have to do something about that."

Strategies for Survival

RICHARD D. WITTRUP, *moderator*

Reactor Panel:

H. ROBERT CATHCART, *President, Pennsylvania Hospital, Philadelphia, Pennsylvania.*

STANLEY A. FERGUSON, *Consultant, University Hospitals, Cleveland, Ohio.*

WILLIAM R. FIFER, M.D., *Director, Regional Medical Education Center, VA Hospitals, Minneapolis, Minnesota.*

DONALD M. KILOURIE, *President, Hospital Shared Services, Schaumburg, Illinois.*

ALAN B. MILLER, *President, American Medicorp, Inc., Bala Cynwyd, Pennsylvania.*

JOHN E. PETERSON, *Executive Vice President and Director, The Valley Hospital, Ridgewood, New Jersey.*

GAIL L. WARDEN, *Executive Vice President, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois.*

CHAIRMAN RICHARD D. WITTRUP: As a member of the committee that helped put this session together, I thought I should add one thing to what has been said. The title of this program needs to be attributed to Milo Anderson, who, as I recall, is the one who came up with it about halfway through the meeting. I hope that you will recognize the usual Anderson hyperbole in that language and sense that I don't think any of us were concerned about survival in a literal sense, at least not those who tend to attend these meetings, although perhaps some others will need to be. Rather, survival in the sense of maintaining a desired level of performance or scope of activities is our topic.

We have this morning what is intended, as some call it, as the show-and-tell part of the program. We have hopefully a list here of seven survivors, and the intent is that against the background of the environment that was discussed yesterday at some length, they would tell us briefly what particular things they have done or their organizations represent that bears on the question of how to survive in Utopia.

With that as an introduction, let me present the first speaker of the morning. I am going to follow the pattern of yesterday and not recite the pedigrees but simply indicate the present affiliation of these people.

We will start the program with Bob Cathcart who is President of the Pennsylvania Hospital in Philadelphia and I think has something to do with the American Hospital Association these days, but I forget exactly what it is. Bob, do you want to begin this?

MR. H. ROBERT CATHCART: Thank you, Richard. My ten minutes is to discuss the survival, at least the survival to date, of the Pennsylvania Hospital.

The nation's first, and probably the best way to put it, oldest hospital, which is 225 years old this year, is caught in the old city and a very mature city; in a city that is losing population, in a state that is losing population and in a community that has changed its characteristics seven or eight times during its history.

It had a reputation of elitism. It had a reputation of exclusivity. It had, and still does have, a wall around its various departments and it had no medical school affiliation, in a city that had six medical schools. It has a history of a charity hospital when the sick poor were a dying race, and it had a certain degree of complacency because of a substantial endowment that permitted it to be a bit arrogant.

Because of these factors, it was necessary to join in with the revival of the community in the early

Fifties, the political revival, and take advantage of the neighborhood redevelopment program and deal with several factors. Establish a medical school affiliation, establish full time academic department heads and then put great emphasis on fee for service, individual solo practitioners, and then take part in the great New Society Programs. It established mental health centers and neighborhood health centers and various social programs of that type.

Let's see what some of the results have been. The community health center, for example, has been obviously of great service to people, and it has also drawn the fire of neighborhood groups. It has drawn the fire of the people who were interested in civil rights and it has been drawing the fire of union organizers. It very well could mean the unionization of the total hospital because of the unionization of one segment.

It has provided inpatients in an area where the patients were needed, in a hospital that needed patients, and it has created a great demand for administrative time and judgment. Neighborhood health centers and various political pressures, various political groups from the community board, (almost an antagonistic development) have demanded uncounted hours of administrative time, judgment and effort. It, too, has contributed to the inpatient strength of the institution.

The institution participated in the development of prepaid group practice activities on a regional basis, and it has been successful in fostering a prepaid practice delivery point which has delivered about 800 patient days during the last fiscal year and has done this at a tremendous cost administratively and just plain old dollars of subsidy of \$150,000 a year. But, we hoped that this might very well develop as a substitute for its historic free clinics and that just hasn't happened yet.

It participated in the maternal and child health programs brought in because of its historic leadership in obstetrical care and is now beginning to become a regional maternity center because of the referral of patients in cooperation with the City Health Department. The last six months for which figures were available in the Philadelphia area, it had the largest maternity service in the City. It is probably the first time in the history of the hospital that it had delivered that number of babies. However, the number of babies being delivered now is

still some 70% fewer than when it peaked some ten years ago.

It has been deprived from physical facilities, and its original building is now 221 years old. It was used for inpatient services until four years ago, so it is still struggling and trying to make its way in the community.

I think that it would be fair to say that it is still operating at least 15% below its optimum capacity. Certainly the decision, the returns from the community and from its own actions, are still not in. Will it be vital, and will it be an organization that can carry on and meet the needs of the community as we enter strong regulation of health care facilities?

The Commonwealth of Pennsylvania has not yet had the control of legislation and mechanisms that we see in other states. Will this institution be able to adapt that and accommodate to that? Will it be able to keep moving in developing strong ambulatory services?

There is a history of ambulatory services, but will it be able to change its rather anachronistic services into services that will be responsive to people who carry Blue Cross cards?

Will it be able to continue its thrust into intensive care activities? The planning of the institution is that in a very short time if you are going to be a hospital, you are going to have to serve intensive care, provide intensive care in the community, or its costs will not permit its providing any care.

After some nearly 50 years of operating losses, the institution has been able to have a slight operating gain during the past three years which may be some index of its vitality.

It has been successful in achieving greater patient days, a gain of about 12% of patient days over the previous fiscal year. I suspect that the best way you can describe this is that ten years ago it was absolutely easy to demonstrate that it would be bankrupt within three weeks. Now we can guarantee that it will be bankrupt only in about 14 months.

You can measure return in that way, but again the question is: Is it prepared for the trends toward ambulatory care, towards greater regulation, towards participation in patient education and health education activities of the community?

The management of the hospital thinks it is mov-

ing in that direction. In that way it hopes to be prepared for this. It is building up a good data base. It is building up good management systems, and it is reinforcing its ties with its community, its local neighborhood as well as with the over-all Philadelphia Community.

Because of time, I think that is the summary that I can give at this moment.

CHAIRMAN WITTRUP: Thanks, Bob.

Yesterday an acquaintance of mine on the program quoted me once or twice and said perhaps the only reason I could still afford to tell the truth is that I haven't built a hospital yet. If you are prepared for truth today, I guess you will get it from the next speaker who has just retired from a hospital, and I hope is now back in a position where he can tell the truth again. Some one who is known to all of you from many years back, Stanley Ferguson, who I see is now a consultant at the University Hospitals in Cleveland.

MR. STANLEY A. FERGUSON: Before I start, let me read this paragraph. It comes from the *Wall Street Journal* of April 15. I have changed a few words to disguise what it is about, but it is to show you that perhaps we are not alone in our survival.

"Finally, the experts were unable to foresee the explosion in the cost fostered by inflation, increasing complexity of technology and production problems.

In 1967, planners usually assumed that if something new and exotic could be built, it would be built. Today cost constraints threaten to keep many futuristic plans on the drawing board. Thus, experts are more cautious in their long-range predictions than their predecessors in the 1960s."

This is from an article that was written having to do with the Pentagon and the Department of Defense. They were talking about modern weaponry and Pentagon experts, but you notice the words are the same. We could fill in our own words to fit our own industry. So apparently survival and insufficient resources are not new only to our field. I think it is always reassuring to find out other people have the same problems we do.

The program yesterday pretty well described the environment in which we are currently living, and perhaps something we can look forward to. I have been asked to describe some of the actions

we have taken in the past decade that recognize some of these environmental factors.

First, let me point out we are a large teaching hospital which is private. We have been associated with the medical school approximately 100 years. We are in a complex which includes schools of Dentistry, Medicine, and Nursing. There has been a history of community planning in Cleveland that is perhaps unique. It reflects many of the characteristics of the community, and therefore, planning in this sense is not a new subject for us.

There have been cost controls to a certain extent through our Blue Cross Plan on reimbursement including capital reimbursement, and I mention this to indicate where we have been.

However, Medicare obviously was a new force in the Sixties, and it was a more potent participant than anyone else we had ever engaged, and furthermore, we had little experience in how to associate with them. Therefore, I would say that since 1965, we have been perceiving that there would be more control from outside sources, and we accepted the principle, I believe, that the program in the future would always reflect outside interests and no longer would solely reflect the interests of the people within the organization (trustees, administration, and particularly physicians).

No longer would we have in-house decisions solely.

As all of you know, in the past decade, or even the past 25 years, if any institution and its staff agreed something was needed, obviously it was in the public interest and obviously it could be financed. There was no shortage of funds.

But then with all this coming along, I think that the price and the cost controls that we have in the mid-Seventies certainly taught us that we had to learn how to say "no," and change our strategy from constantly saying "yes."

By the way, there is a different order of management in order to say "no." Saying "yes" is easy. You don't need to know an awful lot of what you are saying "yes" to if you have all the resources to say "yes," but when you say "no," you then have to demonstrate to the party you are saying "no" to, that you know more about his business than he does or else, talking about rationality, you have to convince him that the facts you have are more potent than those he would propose.

This leads you into the whole area of preplanning

and also more information, appropriate information, not all the information in the world.

We also accepted, I believe, that the hospital was going to be the primary focus of control. I think that all the legislation so far indicates that this is so. Physicians still have a favored position in legislation. Medicare certainly demonstrated that, and you will notice at the present time with PSRO and utilization review, they seem to get their point of view across in a way that the hospitals cannot. This is probably due to the fact that the institution now has become the focus of the attention of the public. So therefore, you are talking about the survival of the institution as well as the people within it.

This caused us to recognize or to accept the fact that the physicians are a major part of the family, the institution. And, it seemed to us that somehow our strategy had to be developed in order to permit the growth of this understanding and acceptance on their part, that the hospital included them as well as trustees and administration. They were part of it.

They had to view themselves in this way, because as the saying goes, "if you haven't got doctors and you haven't got patients, you haven't got a hospital." This meant that we had to start to examine with them their understanding of what their programs were, what their involvement was, and also what their responsibilities were in order to accomplish the purposes of the hospital.

Not only the purposes of their educational programs, not only their responsibilities for their patient care programs, but what together were their responsibilities for the survival of the entire hospital.

By the way, we didn't use the term "survival" when we began, but within the past few years, as a result of involving them in examining their role and their activities and causing them to assume responsibilities as managers, so to speak, it has been interesting that they are the ones who began using the term.

We had one advantage, if you wish, and that is being a large teaching hospital. We had a rather small executive committee which was known as the Medical Council, and under our bylaws, which by the way are very simple (at least the trustees' bylaws are), there was no question about it, they had responsibility for the professional and medical

care of patients in the hospital. These words have been on the record for about 40 years, and they still stand. Nobody ever wants to change them. So they had accepted this and understood it, and it was now a matter of getting them involved to a greater degree than they had been before.

This led, of course, to accepting the fact that there had to be a corporate consensus about what we were about and what we should do.

It so happened that in the early 1950s, the medical school had evolved what has become known as the Case Western Reserve Curriculum, and in essence, what this did was to indicate that the student wasn't farmed out to individual teachers, but that there was a semblance of order and purpose throughout the faculty and that the entire faculty had to be concerned about all parts of the educational process.

This worked in our favor because it caused the medical component, the Medical Council, who are also the directors of the school of medicine departments, to see themselves as having a concern for something larger than their individual departments.

At that time, in 1953 and 1954, we developed a statement of goals and objectives for the medical school and the University Hospitals. This served us well for about ten years in planning and development of programs and facilities, but then about six or seven years ago, it was obvious that the plan had been ante-dated, and therefore, the question was how to get this re-examined.

It was possible for us, because of this feeling of consensus and corporate responsibility that the Medical Council took the lead in this.

We of course, were involved in urging it, and they sat down and spent about six months with one of them acting as the director of this review. They established a view for the next 10 to 15 years. It was very interesting that they, too, talked about survival.

Keeping in mind that we are a tertiary care institution, they had to examine deeply their commitments to care other than tertiary care. This, of course, gets you involved in the whole area of education, how much primary care, family practice, comprehensive care, and all the rest. But they did complete this, and we then submitted it to the Board of Trustees. gained acceptance on the basis

of the principles involved, and since we did not have the in-house capability, we asked outside people to come in and help us to develop this in terms of a long-range plan to 1985.

At the same time we have been doing this, we also saw to it that we developed the management capability in the entire organization, because as I pointed out earlier, the data you need in order to do planning, the data you need in order to manage, constantly has to be increased and improved. Your budgetary processes always have to be further refined.

We took all of this into account, and in developing our management capability, we worked hard to get all levels of management to understand the hospital's overall goals and purposes and also to assign responsibility for initiating programs at the sub-department levels.

I am talking now about other than medical departments as well, to participate in setting standards to be capable of operating with the physician component of the hospital. In other words, it wasn't we and they. It was everyone to work together and also a constant program of upgrading personnel because we felt that we were going to be in a very, very competitive arena.

Also, we believe that, as was mentioned here yesterday, the laws that are passed principally nationally are then translated into regulations, and obviously they are interpreted by people other than those who drafted the laws.

We felt that we had to have constantly available to us, expert people at the legal and financing levels who could participate with us in the interpretations and understandings so that we could get the maximum freedom of action within the regulations as they are written. And, believe me, as someone pointed out yesterday, the regulations don't always reflect completely the intent of the legislation.

I would say on the basis of this that what we try to do, and I believe we have succeeded to a degree, (and now it is a constant attempt to continue this) is to gain acceptance by the medical staff, the trustees, and all the personnel of the hospital. We all have a common goal and it will be the institution's survival which will benefit all of the individuals concerned.

CHAIRMAN WITTRUP: Education has always been an important part of the hospital function, and as

one related to that side of our activity, we have with us this morning, Dr. William Fifer who is Director of the Regional Medical Education Center for VA Hospitals in Minneapolis. Dr. Fifer.

DR. WILLIAM R. FIFER: I am not going to say anything about education at all. Instead I was asked by Joel to share with you some things from our own experience which would seem to be of importance to you. The one that I chose to talk to you about is my activities in the last couple of years as Director of a Health Services Research Center at a "think tank" in Minneapolis called InterStudy.

InterStudy may be known to you as the home of the health maintenance strategy. Dr. Elwood, our President, has been very interested in public policy analysis and research, especially in relation to health policy, and our efforts in the last couple of years have been to influence policy-makers to pay you for results or outcomes instead of your outputs.

I think that we have made some advance in this direction. I would like to spend my 10 minutes indicating what I believe the implications of our advice to policy-makers are to you. The most evident result of our policy advice was, of course, the passage of the public law related to assistance to health maintenance organizations. We believe people are listening to the concept which ties in to what we heard last night that those who pay for health services will begin to pay for results instead of a list of outputs.

So with that general background, I thought I would outline for you in my 10 minutes what I believe is the evolution in your accountability point of view, and may significantly reorient the mission of the hospital and might be a "strategy for your survival without growth."

I thought I would outline briefly in our time together what present day accountability looks like, and what evolving accountability is going to look like. The hospital's choice is either to be involved or not to be involved.

Present day accountability in general is for cost which deals with the questions of necessity or appropriateness of health services. We boil those down operationally into programs that ask questions regarding admission, the length of stay and the consumption of ancillary services. That's familiar in terms of what we know generically as utilization review.

The mechanisms that ask you to be accountable for the most propitious utilization of scarce resources are, of course, the PSRO legislation, the fiscal intermediary, the state agency which controls Medicaid dollars, and a variety of regulatory attempts usually by public bodies which I included under the general headings of rate review, ceilings and freezes. The over-all posture is "we won't pay for things that aren't on our approved list."

The mechanism, the club, is: "Don't pay!" This cost accountability and the regulatory mechanisms that attend it focus on health care processes, what we are allowed to do based on the question of: Is it necessary, and is it appropriate for that patient in his or her clinical situation?

The second arm of accountability, which is countervailing to cost questions is that of quality. In general, there have only been motherhood kind of statements about it because there is no general perception that anything is wrong with the quality of health care in this country (until the *New York Times* published its 7-day series of articles which upset people) and I think we feel no real quality pressure at the present time, certainly compared to the cost containment pressure we feel.

The mechanisms that handle this at the present time are the Joint Commission and the malpractice mechanism, which of course, is becoming more and more potent. In general, whether you do a good job or bad job, you still get paid, and "quality" at the present time focuses much more on input and processes than it does on outcomes. Inputs are the structural criteria or the capability or readiness to deliver a good product, and processes are all those numbers of ancillary services, et cetera, that we devote to the care of the individual patient, assuming that if we do the right thing, the result will be outstanding.

The evolution of accountability will eventually take these foci. First, of all, the present day data for accountability for results will lead us to understand that the data that we have are insufficient, that is, you don't have any "results" data at the present time.

If I came to you and said, "How have you impacted the health of the people that you served in the last year?" you would have to say, "It beats me. I don't know. They went through here alright. We have a head count, and we have a hospital report showing that we spent a lot of days in the intensive

care unit and that we produced 44,000 laboratory procedures more than we did last year."

Those are what we call outputs, and what my colleague, Vernon Wentworth, calls "wing flapping." You produce wing flapping reports and people are pretty soon going to ask you, "I know the wings flap, but does the bird fly?"

Does the bird fly in terms of results or outcomes?

The recurring question that you are going to hear is: What do we get for the money we spend for health services? The current figure is 118 billion dollars total, about 23 billion in Medicare and 17 million in Medicaid. Sooner or later it will not be satisfactory to those who are responsible for the allocation of those resources for you to give them your hospital report and say, "Here is what we did for our share of the billions."

The underlying question that is being asked is: Does the health care system *work*, and any serious discussion of that leads you to know that a definition of "work" is a definition of its impact on the health status of the population that we serve, our communities.

So we believe that evolving accountability is going to focus on results or outcomes instead of outputs.

Now we thought this was terribly revolutionary in the last couple of years that we have been talking about it and writing about it and trying to influence people about its importance.

But you are always humbled by looking at the literature. There was a man named Dr. E. A. Codman who lived in Boston in 1914 and he published a little book which is out of print now called "The Product of a Hospital."

He described "Codman's End Result Method" for evaluating the utility to society of a hospital. Codman died, I might say, in discredit and disrepute. He was thrown off the staff of Massachusetts General by the Cabots and went crazy writing his little book saying that people really ought to be accountable for results. We believe in Codman in Minneapolis. We celebrate his birthday every year. We think he said something important in 1914 that we are saying again in the 1970s.

The directions of quality assurance research are clearly abandoning the question of input which we now recognize as a proxy for results. That is, we

assume that if you have all of the pieces in place structurally, manpower, et cetera, that you are capable or ready to produce the result, but it is only a proxy for what we want to see which was the result produced.

The process lists, we have given up long ago because they become immensely complex, and they really are the brain child of the bill payer, and his only question is: Was it done or wasn't it done?

In the quality area, we care about whether it was done, when it was done, what the result was and what was done about it, and that baffles even the most serious computer program to try to devise quality assurance criteria related to the complex of interacting medical processes.

So we have gone to results: We will say: "Please just be accountable for your results. Go ahead and mix inputs and processes any way you wish. Mix manpower, mix equipment, be as innovative as you possibly can, but give us a result, please."

The eventual product of this will be your accountability for population outcomes, and that means you are going to have to demonstrate some change in health status indices.

I was fortunate to be able to arrive last night in time to hear Dean Wildavsky's very enjoyable dissertation, and I had written here (without knowing what he was going to say) what I call the "Dream of 93-641" which has got to be the world's greatest fantasy. It says that through some legislation an agency will be created which will examine the health needs of a defined population, number one.

Number two, inventory and assemble the resources within a defined geographic area to respond to the needs of that population; and number three, be evaluated in terms of change in the health status of that population.

That is a delightful dream, but I agree with Dean Wildavsky that the new bureaucracy of Health System Agencies is unlikely to accomplish the rhetoric of the legislation.

I don't believe Health Systems Agencies should be the repository of responsibility for health outcomes. I believe they should be delegated to a more accountable point in our society which, to my way of thinking, the hospital can become.

If one chooses the hospital either as an institution or as the industry, there are some implications. First of all, you have to stand up and say, "Yes, it's me. I am the focal point."

This is an aside, but we had a delightful time in the "hypertension year" (which was last year or the year before). You recall the equation: "A half times a half times a half" which said that half the people in the country don't know that they have high blood pressure. Of those who know they have it, only half are under medical care, and of those under care, only half have normal blood pressure, so we multiplied those three together and said that about 12 percent, one-eighth of the people with a perfectly recognizable illness that is controllable, are, in fact, controlled. Our "outcome score" in hypertension is 12 percent of what is potentially possible. Strategizing how we could improve the situation, we realized that if I came to your community and took everybody's blood pressure and identified all the hypertensive and produced my big list, where would I go with it? To the medical school, to the county medical society, to the health department? I don't know where to go with my list of hypertensives from your community. We need a focal point to accept the responsibility for the management of health.

The second implication in getting involved is to stake out the territory, and that of course, is going to be a highly political process that will go on for a long time.

The third point is to define those population needs. That is, you as the recipient of responsibility for outcome are going to have to first do a health status evaluation, a "still photograph" of where you are now in terms of people's health needs in the population you serve.

Next is to assemble resources. It is unlikely to me that anybody other than the hospital, that is the "Neo-Hospital," can assemble the physician and other health manpower resources, facilities and organizational know-how to bring about the results.

Next, you must provide *proactive* health care services. I can't say that word loudly enough. Hospitals have been *reactive* as far as I know since their beginning. Those who came to you for care received care. Those who didn't were not your business.

A major new shift in the emphasis of your services, if you do accept accountability for health care results, is to become proactive. This implies that you would be able to both vertically and horizontally integrate health services.

The next function would be the evaluation func-

tion. Another “still photograph” after you have assembled and applied the resources to your population’s health needs to then print a report, not a hospital report, but a report saying: We impacted death, disease and disability in this decade by the application of these resources, to this degree.

You are going to get paid for results if we have our way in influencing policy-makers.

They are saying that they are tired of cost reimbursement, that it seems (as Dean Wildavsky said last night in the Michael M. Davis Lecture) as though we have the capacity to soak up any number of dollars they give us. I fully agree with him that the policy-makers are eventually going to say: “You health folks can have 8% of the GNP, and no more.” They will give to us as the professionals most able to do the job, the resource allocation by saying: “Here is your money. Here is your challenge. You will be accountable for results. Now go ahead and do those things that give us, as a nation, the maximum bang for the buck.”

The alternative to getting involved, of course, is don’t get involved, and I think there are some implications to that, the major one of which is if you don’t get involved as an industry and as individual institutions, something like Health Systems Agencies which are immensely less qualified to accept the burden will get involved. And we will go through another decade or two, (as Dean Wildavsky described last night) of fact finding, data analyses, consultations, et cetera, which will put us right back where we started.

I want to leave you with just one idea: that if you do accept, in the evolution of accountability, some accountability for health care results, for *outcomes* instead of *outputs*, it is going to fundamentally change the mission of the hospital in relation to society. I think it is a point made over and over again very subtly in a variety of legislation and which I believe merits your serious consideration.

Thank you.

CHAIRMAN WITTRUP: I think, Dr. Fifer, you may have been talking more about education than you were prepared to admit in the beginning.

I do recall a statement once by Bob Cunningham who said the problem with preventive medicine was that neither of the two parties, that is the doctor or patient, were interested in it, so I am going to reserve the right perhaps to open the discussion

period later with a question of whether we may add happy patients on the end of your outcome list.

The next person to speak to us today is Don Kilourie who is President of Hospital Shared Services in Schaumburg, Illinois. You all know where Schaumburg is.

MR. DONALD M. KILOURIE: To begin with, after an introduction like that, I think I had better give you a little introduction to HSS since *it is* based in Schaumburg, Illinois.

HSS is an outgrowth of an institution called The Hospital Research and Development Institute. The Hospital Research and Development Institute is a group of hospital administrators who got together approximately ten years ago and did some consulting work for providers of medical products. The services they provided were in the areas of research and development and also marketing strategies. This has been going on for approximately ten years.

However, approximately two years ago, the individual administrators of this group made a determination that collectively they might be able to set up an organization that might help them. “The whole is greater than the sum of its parts.”

They commissioned the firm of Cresap, McCormick & Paget to study the potential benefits. The benefits as defined by Cresap were significant, and in December, 1975, a 501 (c) separate corporation was set up.

At the present time there are 18 members. There are approximately 14,000 beds in this organization. However, not all the members of HRDI (Hospital Research and Development Institute) participated in it. Some felt that they had regional organizations that were doing the job and others felt it might not be cost effective.

The unique aspect of *this* organization is that it is geographically very, very separate. I will give you an idea of where the hospitals are (I will just go around the geographic periphery to start it): Roosevelt Hospital in New York; Henry Ford in Detroit; up in Minneapolis—Fairview Hospitals. Out to the West Coast with Pacific Medical Center in San Francisco; Memorial Medical Center in Long Beach. Then Bishop Clarkson in Omaha, Nebraska; Baptist Hospital in Pensacola, Florida; Washington Hospital Center in Washington, D.C. These are just

some of the individual hospitals—I am trying to point out the geographic dispersion of them.

There are certain advantages of having a geographically dispersed organization. First and foremost, I believe there is not the degree of competition for physicians, patients, or other scarce resources.

The members, over a period of years, have been sharing data and information among themselves. These are also large hospitals, and in the opinion of their administrators, well run. They have had a relationship over several years, and I think this relationship is a good base on which to begin.

There are, of course, certain disadvantages in a geographical dispersion. First, certain activities are prohibited by the distance. Priorities differ. Regulations differ regarding third-party payors, planning, etc.

In terms of hospital shared services, there are approximately 80 hospital shared service organizations in the country at the present time. Some of the more *unusual* things they have engaged in are reclamation and recycling. Number two, patient outreach programs. Number three, shared fuel oil storage. In addition to that, of course, there are the *typical* shared services. Among them: central purchasing, credit and collection, laundry, management engineering, medical record transcription, purchasing, etc.

What Hospital Shared Services, Inc. has done is to try to focus on the macro aspects of shared services. Some of the things we are engaged in right now, or are in the planning stages, are the following: a financial planning model developed to really try to optimize reimbursement through a mathematical model to focus on price and determine what you can best drop down to the bottom line. Also, an insurance program evaluation, focusing on casualty, medical, and UCB insurance.

Some of the HRDI hospitals have already set up a malpractice company. You might be aware of that.

Next, we are in the process of setting up, along with Advanced Health Systems in Newport Beach, California, a purchase price comparator index of approximately 150 items in five categories that will report out on a quarterly basis. In addition, we are also contemplating setting up national accounts to purchase some pieces of capital type equipment. At the present time, we are not contemplating going the micro route of buying drugs, supplies, and

things such as that. We are limiting ourselves to capital-type items.

Another thing we are interested in doing is promulgating some of the *unique* activities of the individual hospitals. This is something that seems very desirable to the membership. We are in the process of setting up a computer program library so all the systems dollars, or dollars for programming, are not spent over and over and over again. Also, along the computer lines, we are setting up a search and selection type of committee to help the individuals acquire competent data processing individuals.

We are looking at the aspect of equipment purchase and lease as it applies specifically to computers, and peripheral equipment. We are also considering the setting up of some professional development seminars. However, we are doing these just a little bit different than many of the seminars that are conducted by the AHA and like organizations in that we are trying to have these made more cost effective by establishing a rigorous *follow-up program*. I think this will be a very effective type of operation.

I have had the opportunity to personally visit all of the HSS hospitals and I have also had the opportunity to visit many of the chief executive officers or directors of other shared service organizations throughout the country. I would like to share with you some of the problems that these individuals feel they have in dealing with administrators. It will be very brief.

Number one, the realization that the individual hospital is, of course, *paramount* and the service organization is *subordinate*. This, to me, is a very, very basic thing, but for some of the shared service individuals, it is very hard to accept. Number two, the fact that there is not a real commitment on the part of many members. De facto, it is true. Number three, some hospitals will join a shared service organization just to say they are participating. It looks good to their Boards; it looks good to their community.

Another thing I think is very important, but it is a very, very intangible thing—that you really have to *sell* the administrator, and not just on dollar savings. But you have to realize you are dealing with a very complicated organism—a hospital. He is dealing with department heads. It is a very, very complicated thing and dollars are not the total answer.

I would like to deviate from the hospital/health field for just a moment. I have had quite a bit of experience in the hotel business. I have been involved in several hotel ventures in the past couple of years including the ownership of one or two, and I can tell the story on myself. Many times the health profession is criticized for not being as productive or efficient as industrial or proprietary organizations. There are three hotels northwest of O'Hare Airfield: the Sheraton, the Holiday Inn and Howard Johnson. These hotels are spending grossly approximately \$150,000 to transport hotel guests from O'Hare back to their hotels. (I think the real essence of this story could be brought home to you if you would substitute the word "administrator" for "general manager." Substitute the word "hospital" for "hotel" and, last but not least, substitute the word "patient" for "hotel guest.")

We brought the general managers of the three hotels together. This was a \$150,000 problem and we focused on this problem. We came up with some really potential difficulties.

First and foremost, what color would we paint the vehicle? How could a Sheraton potential guest ride in one that has Holiday Inn colors? Some of the other problems: the schedules were not compatible. After all, we leave at 9:30; they leave at 10:00. What uniforms would the drivers have? How could they identify with our hotel? No one said it couldn't be done—but it sure as heck seemed that way.

The next thing we did was got the two other owners of the hotels together and said to them, "Can we get together with the general managers?" Fine. We next had a meeting, approximately one week later, and the essence of that meeting was 180 degrees from the other one. The essence of it was this: How do we do it, and when do we do it?

The rationale behind that, to me, was the carrot approach—here were potential dollars that individuals were going to put in their pocket or share with others in the group. Fortunately, or perhaps unfortunately (I do not know which), there is no carrot being offered as perceived by the hospital directors, the hospital administrators. Instead, it appears to me that the stick method of motivation is probably paramount.

I would also like to digress into another area that is probably not, in the classical sense, a shared service—but we are viewing it as a shared service.

What it actually is, is leasing or sharing management capabilities or talent. Several of the members of this hospital shared service actively are engaged in this particular area at the present time and others have shown a very significant interest in it. In fact, there are several programs going on right now and I am in the middle in terms of sharing information and coordinating some of the activities. Contract management is a term I can use here, but it is probably not the same type of contract management that American Medicorp, AHA or some of the other entities would be talking about today. I am also talking about its applying to a non-proprietary corporation or a proprietary corporation. I do not see the difference.

Six members of HSS are already engaged in some form of this management sharing. Presently, it is all done on a local level, but then in the future, it could—and I would like to reiterate *could*—be expanded out of the local level by bringing several together under an umbrella. It might be a loose umbrella, but it could very well happen.

We have been able to learn several things from proprietary organizations. I will be very, very brief on these, but I think they are important to us.

Number one, the importance of the proper discipline and incentives. Secondly, the achieving of a balance or more of a balance between management and physicians. Number three, the centralization of some decision-making. Centralization is awfully important, however, we feel some de-centralization is effective, hence, there are certain advantages on an individual basis.

Last, but not least, of course, economies of scale. I have a listing of many of the advantages of contract management. I am not going into them right now. Suffice it to say they are primarily questions of quality and of scale which the individual hospital probably does not have the talent in terms of dollars to acquire.

After last night's talk on HSA's, I am very glad I can say this—I have purposely not gone into HSA's to say what we are doing there although several shared service organizations have submitted applications to participate in HSA's in our particular area. I have only discussed today things that we are engaged in at present or actively looking at today.

Going back to shared services, per se, of the future—what do we see for shared services? We feel that shared services is just one of many approaches to improve hospital management, but under the present approach and structure, we do not feel it will really be a truly significant influence in the delivery of health care.

CHAIRMAN WITTRUP: Thanks, Don.

Now for a somewhat different perspective on the matter of strategies for survival, we will hear from Alan Miller who is President of American Medicorp, who has his office in Bala Cynwyd, Pennsylvania.

MR. ALAN MILLER: To be frank with you, I take the question of survival a little more literally than maybe some of you do. What I mean is that as a public company and a profit-making company, we think about survival *all* the time.

Let me try and share that reasoning with you just a bit. We feel that there are certain financial goals we must attain every quarter, that is, we must generate an income return on our invested capital. We must also provide funds sufficient to purchase new equipment and services. That is our charge by our investors, our owners, and we must not fail.

In addition to the financial goals, in order to remain in business, we must deliver a superior service, delivering quality care and maintaining our position in the community. So the company's problem is balance, i.e., providing a superior service and at the same time providing a satisfactory return on invested capital.

We have incentive. If we don't do our job adequately, we will be insolvent, in the worst case, or our assets will be reallocated to others for better use. I am talking in terms now of alternatives for a public company. Some will say, Medicorp has 450 million dollars in assets. They are not being used most efficiently. We will tender for the company and we will reallocate the assets, and put them to more productive use. These are the alternatives to survival of a public company. We are aware of them and it is a good incentive.

When I joined the company and analyzed the business, I recognized that we were blessed two times. We are both labor intense and capital intense.

In addition to that, we have a very independent, highly educated, opinionated and respected group

of people, the physicians, that we have to deal with all the time. So, we feel this is a difficult business.

American Medicorp is a company that is eight years old. As I noted, we are public. We are a network of acute care general hospitals, some 48 hospitals in 13 states. We are approaching 9,000 beds, and we have 14,000 employees.

I thought I would briefly, in the ten minutes that are allocated to me, tell you how we are organized before discussing our survival strategies. Our organization is both centralized and decentralized.

The operations of the hospitals are decentralized and directed through five hospital groups, one in the Northeast, one in the Southeast, Southwest, West and Northwest. These five hospital groups are directed by five regional directors.

Reporting to them are group directors, and reporting to them would be a number of hospital administrators, sometimes six, sometimes as many as eight or nine.

The hospital operations, the day-to-day decisions, the relations with the community, the relations with the HSA in that community when it is developed or the relations with planning agencies are all on the local level, and those decisions are made by the administrator and his staff in consultation with the regional director. We at corporate don't try to run the hospitals. We don't try to provide care for something like 300,000 or 400,000 patients a year, from the Philadelphia headquarters. We recognize we aren't that smart.

The centralized activities, finance and planning, may be of interest to you. First, the financial services department, which is a very large one. Included in financial services would be our accounting, reimbursement, and taxes, (that is a burden that we must bear). We paid 12 million dollars last year in federal taxes.

Also included are an internal audit section which goes out and visits each of our facilities and a management information section, data processing, et cetera.

Financial services have been getting larger. A lot of it has to do with compliance, and we think this is getting to be an unnecessary burden that may not be very cost effective but one that we have very little say about.

We have a treasury department, which is responsible, in addition to finance, for planning and insurance. We had the unhappy task of taking Argonaut

to court last year in Philadelphia, when they sought to unilaterally cancel our malpractice insurance.

We have a legal department that is quite sizable. We have a design and construction department. We have a capital program of \$30 million this year and are planning to reduce it to \$20–25 million. Some years ago it was more like \$45 million a year. We have a purchasing department and employee relations. We are very involved, as all of you are, in labor relations, negotiations, and that means unions.

We have communications department and management services, providing contract services for hospitals owned by others. We also have a consulting service department. Bob Carithers was here yesterday. Previously he had been associated with Booz, Allen & Hamilton. He has been in the field a number of years. He is in charge of consulting services, and these are provided primarily to outside entities. We do get the operational people calling him for a little help here and there, but we try and direct our consulting services and management services primarily to hospitals outside our ownership.

I think that you may find the six operational tenets that the company follows of interest. These are written in our introductory literature to administrators and management people that join the company.

Number one, we call “look outside” and that is our market study, our business analysis, our business plan. Every hospital has a business plan, and part of that plan is an in-depth review of the competition, the market, the nature of the market, the changing population trends, et cetera.

We think that it is most important to look outside first.

Second, we say “look inside,” and that would involve the organization of the hospital, the programs of the hospital, where the dollars are being spent, who is spending them, cost containment, and as part of that, we have two sayings.

One is “buy smart,” which involves our purchasing. The other is “build smart.” We really got into the construction management business because it was forced upon us. After talking to architects and developers about cost control, we felt that there had to be a better way. This was about seven or eight years ago. Now we have been doing all of our own design work, construction bidding, purchasing, equipment specifications, et cetera.

The third tenet is to develop the strongest management team you possibly can. We put a great

reliance on management. As I said at the outset, we are in both a capital intense business and labor intense service business. I think that probably this strategy ought to be number one, but this is how we put it today. We feel that the chief executive of the hospital and the regional management each must get the most out of his respective management team. He must get the people who are in charge of projects to function well and he must be concerned that they are doing the job properly.

We employ consultants, and we urge you to. We urge our executives at the hospital level, if there is a problem, get it resolved in timely fashion. The idea is to get problems resolved, get the job done.

Fourth would be our business plan, and that is to establish goals, create incentives and motivate others so that the goals will be accomplished. Demand performance, hold people accountable.

In our company, just as I was telling you, I recognize very deeply the fact that the company has to do certain things to stay in business, to remain solvent, to continue to provide our high quality services. It is the job of each of our managers to deliver the goal he agrees to attain at the beginning of the year. We demand performance, and high performance people have an opportunity to develop in the organization. Lack of performance generally will be met with a recycling within Mediacorp or perhaps finally some will have to devote their energies to another organization.

It is important that personnel understand that. You have to monitor, effectively, and that's our fifth tenet. You have to monitor performance closely, and that is starting on the hospital level. Any good manager, any good administrator knows what is happening in his organization every day. By any measure, census, what is being spent, how many people are on duty, et cetera. How does he measure in relation to budget?

The regional director and the regional staff, probably on a weekly basis would have a formal meeting or discussion, but they are on the phone back and forth as required. We have a formal corporate review monthly of the operating results, although certainly we are back and forth on the telephone regularly. So you have to set up procedures and monitor them closely.

We pay something in excess of 2 million dollars

a year for our data processing. That is only part of the monitoring costs, the telephone bill is another part and the airline tickets would be the third.

And the sixth strategy is to anticipate and accept the need for changes. After we monitor closely, if things are not going the way we think they should, if performance isn't there, or if situations have changed, or we have not met goals, we are willing to be, and recognize that we must be, flexible. So number six would be to make changes, look for changes, be willing to make changes and be flexible.

I would add in closing another tenet that is not numbered but it is what Napoleon considered as high as any other. He always inquired of new officers, "Is he lucky?"

CHAIRMAN WITTRUP: Thank you.

The next speaker is John Peterson. He is Executive Vice President and Director of the Valley Hospital in Ridgewood, New Jersey. John.

MR. JOHN E. PETERSON: Back to Public Law 93-641 and the HSAs, that was a surprise, it seems to me, to practically all the hospital people in the country. At least, I have never talked to anybody that knew anything about it until after it was passed. But it wasn't a surprise to the planners. I was the only hospital administrator in the country that was registered at the annual meeting of the American Association for Comprehensive Health Planning last July in Seattle. There were two others, but they were on the program.

At that meeting they were celebrating the culmination of all their efforts during the past year to pass that bill, all of which had been discussed very thoroughly, apparently, at their meeting in Minneapolis the year before.

I was impressed. I was impressed that there is now a critical mass of people who are devoted to telling hospitals what they are going to do from now on. They are serious minded. They are dedicated. They are very much interested in what they are doing. They are people who come from the B agencies and the A agencies and the regional offices of the HEW. They come from the university programs, and together with Congressmen, the staff members of the members of Congress, they now form an effective coalition to make sure that somebody does something about us.

There are more of these people coming. It seems

to me every major university now has a program in health planning, and after just a few years there are more health planners than there are hospital administrators.

Of course, all of these people have to keep busy, but I have even more biases about HSAs besides the fact that maybe they can't be effective in the long run. Many, if not most, of all of the HSA Boards that have been formed so far are way too big to be able to run.

An alarming number of the Board members have never been involved in health planning before, but then that is not unique. Most people who have been involved already know little about how our current system works. But the more you talk to people in other regulated industries, the more you realize that that is not unique either.

The name of the game for HSAs is controlling health care costs. That is axiomatic, but it is not always understood. Therefore, 90% of what the HSAs are going to be doing is directed toward hospitals and medical care in hospitals, and then we come in to a funny twist about how the HSA Boards are organized.

If that is so, why aren't all the provider members hospital administrators and physicians? And, why do we include all of the dentists and pharmacists and psychologists and chiropractors and all those other people who are talking about what we are doing? So we have the blind leading the blind.

The health systems plan of the HSA, of course, is really a compilation of plans for individual hospitals.

Then you get to the funding of the HSAs. I used to worry about what if they really did get that 50 cents per resident, and then the dollar per resident. Now I am worried because they only get 20 cents because then I look and say, "Can the staff really spend the time to nurture that large diverse board that has a little knowledge and put the criteria together by which requests for certificates-of-need can be measured, and process the certificates-of-need. You have to watch them. (Hospitals not now in Certificate-of-Need states will have to watch the process.) I don't think so.

If the HSA's have the certificate-of-need legislation (which they will go after very quickly, if they don't already have it) they are going to jump into that right away with little idea of how to go about doing it.

On top of that, there is abundant opportunity for confusion, ambiguity, and conflict between the state regulatory agencies and the HSAs.

What is the strategy for the individual hospitals? It has already been said.

I have watched some individual hospitals over especially the last ten years, innovative, progressive people stay away from any participation at all in the planning process, and it appears they believe they are not compromised by the implicit agreements that have to be made by people who do participate in the system. They can act independently. They don't waste time. They can concentrate on maximizing potentials for their own hospitals, and sometimes I really frankly envy them.

The other obvious strategy is to get involved—work with the planning agencies—use influence to help make the system work in the hopes that that is in the self-interest of the hospital. That is for each hospital to decide, but my message is really about hospital associations.

It seems to me hospital associations have shied away from the planning process way too long. There are obvious conflicts of interest between the hospitals they represent. So they don't get rewarded or get much credit from the hospitals for being involved.

Even after Public Law 93-641, my guess is that they still don't, but at least in the states that have had the Certificate-of-Need Law, some hospitals seem to recognize a need for an agent to monitor the HSAs.

Individual hospitals which are overtly critical of the planning process of the planning agencies can get hurt, and I can testify to that personally.

In New Jersey we have one of the most stringent Certificate-of-Need laws of any state. Now the association officers have authorized the position of Vice President for Planning for the New Jersey Hospital Association. Jack Owen hired a senior member of the State Health Department.

This man knows a few people in Washington. He obviously knows a lot of people in Trenton. He knows people in the Region II office and in the HSAs, and the HSA is where we still believe the action will be for the individual hospitals.

The Vice President for Planning's first committee is composed of the two hospital members of the present State Health Planning Council, and one member each from the Boards from the five emerg-

ing HSAs in New Jersey. It is obvious he needs other inputs, particularly from the people who actually do planning for the individual hospitals.

We see these functions for the State Hospital Association: 1. keep in touch with Washington and the regional office. 2. Know what the planning and regulations say and what they mean, and comment on them independently when they are published, and review and comment on the grant application of the HSAs every year. 3. Arrange for and participate in the education of HSA Board Members and staff. 4. Insist that the planning criteria of the HSA are consistent with each other, and apply pressure when the HSAs are unreasonable or arbitrary.

One prospective HSA in New Jersey last month issued a list of questions to be answered on all Certificate-of-Need applications. In 95% of the cases, the questions are entirely irrelevant. It reminded me of the interrogatories we get from plaintiff attorneys these days.

The association can and did react strongly on behalf of hospitals who have to live with these HSAs. Beyond that, we think that the association has to articulate the need for, and apply pressure to, increase the interface of the hospitals and the HSAs.

I am concerned about the technical advisory committees of planning agencies that have to have a majority of consumer members. When you talk to them about the critical problems of heart surgery or dialysis centers or services like this, it is disheartening. We must help the HSAs to really understand the significance and the impact of a medical community which is the medical staff of an individual hospital, that it is a unique and a discrete entity, which now they don't seem to comprehend at all.

Then take the initiative in developing planning criteria in the areas where cost containment is really practically possible and desirable. We think that the association can start talking about that and hospitals can start talking about it and start telling the planning agencies: "Look, this is where we think you can help us contain costs."

Develop definitions for service areas. Gee, we don't know anything about service areas. At least, in New Jersey we still talk about service areas for hospitals instead of service areas for all the various individual services within the hospitals.

Take the initiative in encouraging exchange of information between the hospitals, between the medical staffs of the hospitals, between Boards of Trustees and even the administrators themselves.

Then try to get the HSAs to realize that there is debate about this. We believe that one should try to get the HSAs to use a Certificate-of-Need as part of the process of planning rather than an end in itself.

As I go over these, there are sort of obvious kinds of responses that are going on around us, but we have had the Certificate-of-Need Legislation in New Jersey for how long, David, four years?

MR. WAGNER: Five now.

MR. PETERSON: Five years. We are only beginning our response this year.

It may also appear that the association is doing some of the work of the HSA. I hope it does, I am dismayed at the lack of criteria for planning that I have seen.

Now the Certificate-of-Need law in New Jersey required long-range plans for hospitals, but that had been implemented, and so two years ago as a member of the State Health Planning Council, I made a resolution that Certificate-of-Need applications not be considered after January 6, 1977 unless a long-range plan had been filed with the State Health Department. It took Dave Wagner and his staff a while to get it done, all of the regulations and the guidelines. Of course, you had a poor committee, right?

The hospital association did participate in the guidelines, probably not as much as we should have. I am critical of that. The new Vice President for Planning actually wrote that planning guideline, and we hope that he will assist the hospitals to meet the new requirements.

One of the important byproducts that we see coming out of this is that we are now getting some good in-house planners like Tom Young in Virginia, and the association is beginning to use them to initiate rather than to react for planning for health care.

Thank you.

CHAIRMAN WITTRUP: Winding up our series of sessions this morning is Gail Warden who is Executive Vice President of what I think all of us have come to admire as a very vigorous and imaginative institution as will even be indicated by its hyphen-

ated name, Rush-Presbyterian-St. Luke's Medical Center. If you merge with any more, you are going to have to go to an acronym. Gail.

MR. GAIL WARDEN: Thank you. Being from Chicago and sitting here, I couldn't help but think about the relatively recent fact of how amazing it is that in health care administrators' meetings throughout the country, people have started to "open up." Administrators have become a little more honest with themselves, as well as among themselves, about what they are doing.

Clearly, for that reason, it is an experience for me this morning because I am sure there are several people in the audience from Chicago who have said, "What the hell is Rush all about?" In addition, as I scan the group present here this morning, I see several former students who have been on the inside and know what we are doing via their externships at Rush. Therefore, I am sensitive as to what I have to say and how to say it.

In the ten minutes that I have, I would like to talk about four concepts which I feel characterize what we have been attempting to do in the last ten years or so.

In 1958, Presbyterian and St. Luke's Hospitals, which were two teaching hospitals here in Chicago, affiliated with the University of Illinois, merged and moved to one location which is our current site.

Hence, Presbyterian-St. Luke's Hospital began developing toward a major effort in education in 1966. A study done by Dr. James A. Campbell, President of our institution, was commissioned by the State Board of Higher Education. In that study, a number of things were called for to occur in the State of Illinois in the areas of education and the health fields. Most important was the identified need for the production of more physicians in Illinois, the need for the use of hospitals within the state as clinical centers, and the need for support from the state, both to public and private institutions, for the purpose of increasing the production of health manpower.

In 1969, our institution had continued to charter the old Rush Medical College which had been started around 1841 and deactivated during World War II. We began discussions with the alumni of the old Medical College and merged in 1969 with the Rush Medical College alumni to form what is known as Rush-Presbyterian-St. Luke's Medical Center.

Aside from recognizing that the alumni were getting pretty old, we realized that if we wanted to get some money, we had to act fast. Therefore, we formed a new Board with alumni representation and began development of what we have come to call internally the Rush University System for Health.

With this concept exist several characteristics. The first characteristic of it, which I believe is something that we all have to be concerned about in the health care field, is that there probably is not as close a relationship across the board as there should be between the academic and care elements of health.

We viewed merging the hospital and the medical college into one organization as an effort to do something a little bit different, even though it had been done in one or two other places. It would allow us, as an organization, to address both the academic needs, or health manpower production needs, and the health care needs.

This unification of academic and care institutions, in our opinion, was very essential to the future of the system that we all know and became the number one priority.

A second consideration was that there ought to be some numbers to start from in terms of the population a system would serve.

We recognized that somewhere down the road that if there is not some way of identifying numbers, somebody will draw lines on a map, which is in a way what is happening. It was our strong feeling that we ought to identify some numbers, try to work with them, and hope that when it reached the point where lines were being drawn on a map, we might have established some precedent for working with people that we wanted to work with, rather than being told what institutions ought to come together into some kind of system.

With this in mind, we developed what is a fairly simplistic formula. We took the number of medical schools and the number of people in the State of Illinois and concluded that each medical school and the system that developed from a university hospital or a tertiary care center should serve approximately a million to a million and a half people in the state.

We also arbitrarily adopted a bed formula, which was essentially three beds per thousand, or 4,500 beds in a system.

We adopted a tertiary bed formula of one-tenth

of the number of beds that were identified, which meant about 400 to 450. We developed, again arbitrarily, what we thought would be the health manpower that needed to be produced to support the care of a million and a half people.

We factored in the numbers of people who leave Illinois to go to California—and you may be interested to know that there are more medical students who graduate from schools in Illinois who go to California than who stay in the State of Illinois. We arrived at a figure of 100 medical students per year to support a million and a half people. Then we arbitrarily said there must be four or five other health professionals of one kind or another—nurses, allied health professionals, managers and so on—needed as support. The system, therefore, ought to produce approximately 400 to 550 allied nursing and health personnel.

We also felt that such a system ought to have responsibility for its fair share of the medically disadvantaged, which we identified as approximately 200,000 people in the inner city and an equivalent portion of the rural population in the State. We set about attempting to develop a network of affiliated hospitals in which students would become exposed to a variety of practice settings in a broad socio-economic population. The medical center as the focal point would take responsibility for continuing medical education and would provide faculty appointments to medical staff, nursing staff and others who wished to participate in the educational programs. The location of health manpower in all these practice settings would be encouraged as the system developed.

Out of that has occurred the development of two such networks. One is the care network which now consists of approximately 3,600 beds and 8 hospitals. We started with an affiliation arrangement which was not unlike the typical medical arrangement. We are now in the process of renegotiating the relationships with these institutions with the greater emphasis on the potential management relationships that might take place in terms of sharing. Programs to be located in one institution or another within the network are being identified. With two institutions, and probably three in the very near future, we have developed what is known as an association. This is a closer relationship than the affiliation, with

a joint policy board of trustees from two institutions. It is now a one-on-one relationship. Hopefully, it will become three or four institutions working together with a joint policy board. These institutions should have a fairly firm commitment to attempt to do everything together that is possible in a sharing sort of way.

For Rush-Presbyterian-St. Luke's, this is somewhat of a new experience because we have been an institution that has had a fairly good set of resources. We have had the ability to do what we wanted to do over the past few years, and developing a sharing relationship with others has brought us to realize that other people have opinions and programs to which they would like to give priority. I think for our management, particularly, it has been a positive experience, although a difficult one at times.

Another network that has developed, and one which probably is running much more smoothly, is an academic network which we have put together in order to be able to produce nursing and allied health manpower from the kind of setting that we have. In looking at the need to produce baccalaureate degree-type nurses and baccalaureate and master's degree types in the allied health sciences, we concluded very early that with our kind of setting we could not afford to teach English and a lot of other basic courses that one needs to become a health professional.

With this in mind, we developed a relationship with what is known as the Associated Colleges of the Midwest. This is an organization of 13 small liberal arts schools in the Midwest—three each in Illinois, Wisconsin, Iowa and Minnesota and one in Colorado Springs. We are also affiliated with Fiske University in Nashville and the Illinois Institute of Technology here in Chicago.

These institutions have agreed to admit to their schools, in a pre-health curriculum, students who would be on their campuses for two years and then would come to Rush-Presbyterian-St. Luke's for the last two, three or four years if they decided to go on to a Master's degree.

This program has provided a new market for these colleges, most of whom were having the kinds of troubles that all small liberal arts colleges are having. It has also been a boom for us because it is producing a very high quality student to enter into our academic programs.

The last thing I want to touch on quickly might be viewed as a self-assessment of the institutions in our network. It is the development of what we have come to call the Office of Corporate Program Development, an office within the medical center which has placed in our management structure a major line position for looking at what we are doing. This office is responsible for looking at the programs that we have, the overlap that exists within our own organization, as well as the organizations that we are affiliated with, and new approaches from across the country. It weighs what we are doing against what we are saying.

The Office of Corporate Program Development is composed of a staff that is supported by the Kellogg, Commonwealth and Henry Kaiser Foundations, as well as from operations. It currently works through task forces with internal and external membership.

Our first task force has just completed its report, and that task force is addressing the issue of where we are going in ambulatory care in view of the state policies on Medicaid. It is asking some hard questions about what we really need to teach medical students and about our real commitment to the community. We hope that this office will serve as somewhat of an internal conscience for us as we move forward.

I appreciate the opportunity to talk to this group. Thank you very much.

DISCUSSION

CHAIRMAN WITTRUP: I will ask my question of Dr. Fifer, whether in his scheme of things we can add satisfied patients to your list of outcomes?

DR. FIFER: Yes, the patients' satisfaction is related to quality assurance. The result you attain by virtue of patient compliance has a great deal to do with the clinical result. If we do all the right things and give the patient his or her medication and he is so dissatisfied that he doesn't take it, then the result is substandard. You need to bring the patient into participation in his own care, and that is where patient satisfaction impacts the result.

In terms of the HMO strategy, the only recourse a dissatisfied patient has is to drop out of the system. To whatever degree you manage patients badly in terms of their satisfaction, will show up in your

final report, as a great deal of disenrollment from your population for which you are responsible.

CHAIRMAN WITTRUP: I also make reference to the patient who wants a coronary bypass. Some people now suggest that it is very difficult for anybody to show that somehow the health index of his constituency has been improved by that very expensive procedure.

DR. FIFER: Where the patient's expectations are unreal is a major problem. Patients see Marcus Welby say that coronary bypass is what they need and your professional group decides that they do not, then they can disenroll unhappily. You can say, "We cannot buy into everything the patient demands," but you will have to have justification for your refusal to do the procedure with a scientific basis.

MEMBER: The topic of this session was "Strategies for Survival." And yet we've heard Gail Warden and some of the other speakers address the subject of survival by growth. That conflicts with the notion that we are a bunch of good fellows working together and approaching the legislature hand in hand to solve all our problems. If individual institutions are going to grow or address survival by growth, we inherently are going to conflict with our colleagues and not always be able to approach the power structure collaboratively.

MR. WARDEN: I am simply saying that the growth, if it takes place, will take place by institutions growing together, and working together. As far as one institution growing independently, that is becoming less and less of a possibility.

For instance, at Rush-Presbyterian-St. Luke's, any growth that takes place will take place because we are able to develop a new relationship with another institution, rather than planning to build another hospital. When our branch hospitals failed last year and we couldn't afford to build them, the point was driven home strongly. The inter-institutional approach of institutions combining to form a system is what must happen.

CHAIRMAN WITTRUP: I would like to ask Alan Miller if he perceives this as a growth industry.

MR. MILLER: From the aspect of our company, we must grow, there is not much I can do about that.

That gives us incentives, to look to more services, different services, different ways of doing things so that we can accomplish the growth.

As Gail Warden has said, a particular institution (and we have certainly a number) may not be able to grow in terms of the old way of measurement, more beds or more gross revenues and more services. Rather, we have been combining services. There will probably be a number of tradeoffs in terms of what services one entity or one group will give and trade with another group to provide those services, perhaps eliminating them elsewhere and resulting in a more efficient cost for providing the services.

From the viewpoint of the industry, there is tremendous demand, and there is tremendous education and stimulation through Marcus Welby and the like.

I think that is a growth industry.

How it grows, how it is allocated into what areas, and to what extent it grows, I don't know. We talk about this all the time in terms of the future of the company, and the future of the industry. Certainly health care will not stop at 118 billion dollars. I don't know how it will be slowed, but there are all the prospects for more dollars coming in and more growth in this industry.

MR. FERGUSON: We need to put together in some sort of a relationship hospitals which can meet the future better together than they can individually.

Some have asked their state hospital association to assume responsibility in this area since failure to seek these relationships on our own will probably result in the HSA suggesting with whom we are to be related.

You might want to say to your state association, "Suggest how we can do it." I must admit I feel that hospitals should take the position that as providers of an important segment of health service, they are capable of developing proposals for a unit of service or serve a population. The challenge I see will be: How do you go about getting individual physicians, members of medical staffs, individual hospitals, and their trustees and administrations to ac-

cept the principle that no longer should they necessarily relate to the society (which is much larger than their own community) on an individual basis?

I gather from what Gail Warden said that they went out to examine a number of hospitals and said, "Here is the community that we believe you should be related to."

They had to sell them on the idea that this was a community they would recognize. This may be the major role that hospitals will have to take if we are to prevail on HSAs and any other outside group that proposes what the hospital system ought to be.

This is going to be a new challenge because we have not used any of our state, local or national associations to act in the role; we have never asked them to take the initiative in this area.

I was interested in Mr. Peterson's remarks, that they have urged their state association to take some initiative in suggesting how this might be done, so that they could go to the HSA and make some proposal and not have it await the decision of the HSA on their plan.

DR. FIFER: When I inferred that a hospital is going to be increasingly accountable for results, I predicted horizontal and vertical integration in the industry. I believe I see that happening.

The people who are going to sit down with the map (which is a temptation in the HSA type thinking) and draw out a designated area, fail to recognize that there is vertical integration. There are primary, secondary, tertiary and quaternary health services.

I suspect the emerging organization that will have the capability to accept the responsibility for health outcomes in populations will be one which organizes the care system in such a way that it can accept responsibility for the whole range of health services. I don't see that emerging as some kind of a simple drawing of lines on a map. I see that as an organizational arrangement much as has been described in Illinois and is occurring in other states.

In Minnesota now we are seeing an effort to franchise hospitals by means of a categorization or designation of their emergency rooms as Category 1, 2, 3, 4 and so forth. There have now been guidelines set up for the so-called stroke hospital which were done by the Joint Commission under contract with HEW which required structural process and outcome kinds of criteria for evaluation. So we

are beginning to see a new and interesting way of integration for accepting responsibility that I think is a matrix between horizontal and vertical.

We must get out of our minds, the simple notion that we will take a map and carve the territory. It is much more complex than that.

CHAIRMAN WITTRUP: I assume one of the purposes of this meeting is to enrich the language. What is quaternary?

DR. FIFER: I won't take the responsibility for defining these personally, but primary, secondary and tertiary refers generally to the subspecialization of physicians. There are about four primary care providers. The internist and general surgeon are secondary and the neurosurgeons are the tertiary services.

The quaternary services concept came about with such things as neonatal intensive care units, shock centers, transplant centers, spinal cord injury centers and so forth; in which we recognize that although important, there are a group of services that are sufficiently infrequent that they go beyond the traditional categories of physician health man power. I think there is some general consensus to call those sky blue things that are regionally organized quaternary health services.

MR. PETERSON: A professor at the University of Toronto told me that the provincial governments in Canada have already designated the precise role of each hospital in Canada. Perhaps this came about inadvertently, but we must consider the HSA plan and the implementation plan of the HSA as very similar. What can they implement? They can't implement anything. They can't deliver any kind of service or goods or anything else. They are telling us what we are going to implement and deciding exactly what we are going to do.

CHAIRMAN WITTRUP: I can't help but observe, having spent the better part of 25 years at meetings talking about planning which hospitals individually never seem to be able to do, we now decide we can do regionally what we can't do locally.

MEMBER: I thought I heard Don Kilourie say that he does not believe that shared services will be a truly significant influence on the delivery of health

care. If that is what you said, Don, please explain what you meant.

MR. KILOURIE: That is correct.

Under the present structure of the industry and with HSAs coming aboard, I really see efforts like those at Rush-Presbyterian-St. Luke's having much more effect than the classical hospital-shared service. Contract management or management groups may become more insignificant in the future. Yet, I do not see the cost effectiveness of the typical hospital-shared service justifying itself after a period of several years.

MEMBER: Do you feel that hospitals shouldn't be in shared laundries, computers or system engineering groups?

MR. KILOURIE: I am mainly concerned with innovative programs. There will be shared laundries in the future. There will be shared purchasing in the future. This has been the classical approach to hospital-shared services.

As things change in the future, mergers and affiliations will become associations, which could and probably would take the place of many of the activities that are classically performed by hospital-shared services.

MR. KINZER: You are saying, that we are going to develop a hospital system instead of the state hospital associations or hospital councils being so heavily involved in shared-services.

MR. KILOURIE: I think the trend in the hospitals that I am working with indicates that to me.

MEMBER: Why haven't the university teaching hospitals through the AAMC and the spin-off from that become involved in this process. They could speak to the issues of innovative programs in the delivery sense, and also integrated educational missions. They could present a national view of where medical education is going which certainly is lacking right now.

MR. KILOURIE: I feel there is a need for something like this. There remains the question of implementation. I was trying to point out in the example of the hotel operation, that I sincerely be-

lieve there has to be some sort of an incentive for hospitals to engage in something beyond their own walls. Today I do not see that incentive really provoking the individual administrator to go out into the community.

CHAIRMAN WITTRUP: Are you saying that instead of the state association having a shared computer, and selling services to various hospitals, you are predicting that a consortium, alliance or association of institutions will form, and it will have a computer. Is that what you are saying?

MR. KILOURIE: I think this could very well come about. However, I am not saying if a state association has a data processing center right now that it should be taken over by this consortium. My perception is that the results of hospital-shared services have really not been that significant.

MEMBER: I would like to ask Mr. Warden a question about the 13 or 15 small colleges that are affiliated with the Rush medical system.

I recently had occasion to review relationships of hospitals in New Jersey with a variety of schools. These students are going into laboratory technology and they have a year to spend in the clinical setting in the hospital. The relationships between the hospital and schools vary as far as tuition funding is concerned, going from zero to considerable amounts.

How do you approach the matter of tuition for those students that are at your place for clinical affiliation?

MR. WARDEN: We charge them tuition because the College of Health Sciences and the College of Nursing are separate units within our organization. If some one goes to Knox College here in Illinois for the first two years and then comes to go into the baccalaureate program in nursing, they pay tuition which actually is commensurate with what was charged in the Associated Colleges of the Midwest for the last few years. The same is true in the laboratories.

CHAIRMAN WITTRUP: You learn the system of educational finance which is to sell the same thing as many times as you can so that you can finance the things that nobody will buy.

DR. FIFER: Rush-Presbyterian-St. Luke's is an ideal HSA as it sits. Gail Warden now has the integration of hospitals and the integration of educational institutions to support the development of manpower, and provide services. I would sign a contract with him tomorrow and give him a million people to be responsible for.

CHAIRMAN WITTRUP: I would like to ask Mr. Miller another question.

Extrapolating from the nursing home industry, it has seemed to me that the investor-owned providers do best in an environment which is dominated by the non-profit. There they can tie in to that income system and not create that much tension. Whereas, when you get a situation as we have in some cases with the nursing homes, where they are dominated by the investor-owned system, then the payers get very nervous about somebody lining their pockets as a result of payment for these health services. Then, we tend to get an under-financed system and have a great deal of difficulty.

Is your branch of our industry concerned at all about that? In some parts of the country if proprietary becomes the dominant system it might find its financial situation very difficult, or is that just the sort of thing that hasn't arisen yet which is part of your own strategy for survival? Do you try to keep spread out or worry about concentrating?

MR. MILLER: We are not in the nursing home business, but let me give you an observation about the nursing home business.

I think the nursing home situation is very hypocritical. The reason we didn't get into it or didn't want any part of it is that there is an incentive in the nursing home business to do the wrong thing. You get a reimbursement that is artificially low, and you ask someone to stay in business and pay taxes. What are they supposed to do? The only place that you can be efficient then is not to feed people and not to clean them properly and let the plants run down. That is a terrible situation, so we never got into it.

I am not a social scientist, I don't know how that problem gets resolved. We are not facing it when we allocate \$16 or \$17 per day for the care of a person and expect someone to deliver good care.

CHAIRMAN WITTRUP: My question was specifi-

cally if in some segments of the country the investor-owned hospital became the predominant system so that they set the level of reimbursement, not the nonprofit, would there be some risk that the same thing would happen? Where you have a nonprofit basic system, you have a lot of community pressure to keep the level of income high. But, in an investor-owned system, it would seem to me that the temptation to regulate and restrain on the part of the authorities might be irresistible.

MR. MILLER: I agree with what you are saying in part, but you do have the concept of fair return on equity and fair return on invested capital, and that is where you get into the major fight over regulation.

Generally, the people in America think that the profit margins of corporations, the per cent of the sales dollar, is 30 or 40 per cent, when really it is five. That is an enormous misconception. If you are going to have a private system or if you expect people to allocate dollars into a system, then you have to provide a return. And, in England there was no return provided, and those dollars have gone out of the country.

I believe in a return, and I believe in a profit. I don't know how they came up with the term investor-owned. That is euphemistic. I believe in a profit, but I think also in the long run if you are going to be in business, your product has to be superior. It has to be competitive, or you are not going to be able to be in business.

You can't fool people. You must provide a good, quality service. If you can, you will get a return for it. If you can't, you ought to not do it.

MEMBER: One of the "go" words for many years now has been incentive reimbursement. You are in favor of that, and you are on the right side of the street.

I am wondering if what Mr. Miller was telling us about nursing homes and quality could be possibly construed as a little lack of faith in the results produced for the patient by incentive reimbursement.

DR. FIFER: The incentives are topsy-turvy in the care of the aged in that the Medicare agency will pay you an extra \$2.00 if, instead of getting poor Mrs. Murphy able to feed herself, you keep

laws to incorporate the ideals of a system, and therefore pursue those goals?

MR. WARDEN: The first goal is an attempt at joint planning, and that is what I was talking about when I was saying that I think all the institutions are having a little difficulty in settling into such a relationship.

MEMBER: I would like to redirect the last question about the role of the trustees to what appears to me to be an unlikely panelist, and that is Mr. Miller.

You know, presumably in the for-profit, especially the national corporation, you don't have to worry about the trustees at the individual institutional level. But then again, it must be particularly difficult for the manager to relate without some kind of local input. I presume you try to set up some kind of model for local involvement. How do you control that?

MR. MILLER: For the over-all entity, obviously, we have directors. They are responsible for the operation of the company, the planning of the com-

pany, the allocation of the resources, what the company does, its honesty, its integrity, and so forth.

The directors are responsible for the whole operation, they oversee, have an audit committee, meet frequently and get all kinds of reports. So from that standpoint they are responsible for how the company functions in all the states we function and any place you might work abroad. Literally everything we do.

In the local situation, our general responsiveness would be to the community through the physician and the administrator. As I mentioned, our regional directors have to deal with the local board which is made up of physicians and management. The physicians are representing the constituency in that area and the company is responsible to them. They approve budgets. They make the requests for services. They discuss quality, complaints, anything and everything. The boards of the local hospitals are a group that the local hospital has to respond to, and if the response is not satisfactory there, then they would carry it up to management on the corporate level. I believe that if it weren't responsive enough, then they would carry it to the Board of Directors who, in effect, would be the trustees.

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