The Hospital and Cost Containment: Impact and Response

Proceedings of the Twenty-fifth Annual George Bugbee Symposium on Hospital Affairs, May 1983

CONDUCTED BY THE GRADUATE PROGRAM IN HOSPITAL ADMINISTRATION
AND CENTER FOR HEALTH ADMINISTRATION STUDIES

GRADUATE SCHOOL OF BUSINESS

UNIVERSITY OF CHICAGO

The Twenty-fifth Annual George Bugbee Symposium on Hospital Affairs conducted by the Graduate Program in Hospital Administration and Center for Health Administration Studies of the Graduate School of Business, University of Chicago, was held at the McCormick Inn, Chicago on May 19-20, 1983. These symposia are a reflection of the strong concern of the Graduate Program in Hospital Administration with complex current issues in health care management.

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

Special thanks are due Mrs. Margarita O'Connell and Mrs. June Veenstra, who staffed the symposium.

TABLE OF CONTENTS

INTRODUCTORY REMARKS 1

Ronald M. Andersen

COST-SHIFTING AND THE HOSPITAL 5

Frank A. Sloan and Edmund R. Becker

CAPITAL ACCUMULATION AND THE HOSPITAL 14

Arthur J. Henkel

REIMBURSEMENT METHODS AND THE HOSPITAL 24

Howard Berman

REACTOR PANEL 34

DIAGNOSIS-RELATED GROUPS AND COST-CONTAINMENT 39

Joel May

CASE REPORTS FROM TWO INDUSTRIES ON COST-CONTAINMENT 48

Aija Ronis, Harry Malone, and John Kaminski

HEALTH ADMINISTRATION, COST-CONTAINMENT, AND EQUITY: NEW PROBLEMS, NEW PRINCIPLES? 63

Daniel Wikler

COALITIONS AND COST-CONTAINMENT 76

Willis Goldbeck

REACTOR PANEL 88

HMOs AND COST CONTAINMENT: EXPERIENCES IN MINNEAPOLIS-ST. PAUL AND CHICAGO 95

Odin Anderson, Bruce Butler, Claire Kohrman, Ellen Morrison, and Terry Herold

REACTOR PANEL 125

REGISTRANTS 133

INTRODUCTORY REMARKS

Ronald M. Andersen, Chairman

RONALD M. ANDERSEN. Welcome to the twenty-fifth annual George Bugbee Symposium on Hospital Affairs. I'm Ron Andersen. I'm sorry we can't produce better weather for you but I'm sure we'll keep things warm and sunny inside. The symposium is directed each year toward alumni, friends, and colleagues of the Graduate Program in Hospital Administration and the Center for Health Administration Studies of the University of Chicago. The symposium is planned jointly by the council of the alumni association of the University of Chicago program in hospital administration, whose president this year is Bob DeVries, and the faculty of the program. The coordinator of the symposium is Odin Anderson. Odin Anderson and I would like to thank and acknowledge Margarita O'Connell and June Veenstra for their fine efforts in making this symposium go.

The purpose of our symposium is to address a significant issue of concern in the organization and management of health services. The subject of this year's symposium is the hospital and cost containment: impact and response. Of particular interest is the private-sector reaction to current and pending government initiatives to contain cost increases in medical care. Our fine group of presentors will help us to take a critical look at strategies of cost-shifting, capital accumulation, and reimbursement methods as they relate to hospital viability. We will also examine a number of specific cost-containment programs to learn what we can about their effectiveness and their impact on the providers and the patients served.

This is a special symposium, marking the twenty-fifth in our series. The annual event began in 1958 under Ray Brown and has been nurtured in more recent years under the leadership of George Bugbee, who directed the Center from 1962 to 1970. Three years ago the symposium was named in honor of George. In recognition of the contribution of these two leaders--of course not only in the development of this symposium but also in the overall fields of health administration and health administration education--we'd like to take a few minutes to recollect with George and a colleague of George's, Richard Johnson, who, in addition to his many other accomplishments and talents, particularly for our purposes here today, is a graduate of the program, a faculty member of the program, and helped Ray Brown organize the initial symposium. We'd like to have George and Dick come up and speak with us a bit about the symposium and its development in the field.

GEORGE BUGBEE. Richard, I think age gives me priority here.

RICHARD JOHNSON. Talent as well, George.

MR. BUGBEE. He has to be careful. I think I persuaded

Richard to come to the American Hospital Association just about the time he graduated from the program; or he was with Ray at the time, and he later went back with Ray, so that he has been very much involved with the University of Chicago as well as with the program.

First, this is really the first opportunity I have had to express appreciation to the powers that be, who I suspect are Odin and Ron, for naming this symposium after me. With a name like "Bugbee" it took a certain amount of courage, I should think, on their part. I never am quite sure whether to attend this symposium to bask in the honor or to stay away out of humility. I think maybe the latter would be the choice, but here I am.

Dick and I both attended the first symposium, and Ray Brown. It was really the first such venture, and a complete review of education for health and hospital administration--and Ray assembled everyone who knew much about it, I should say, or had ideas about what the future of that education might be. There were not transactions, but a compilation of the papers people gave; it did have history. Both Richard and I attended and I certainly remember that the program was excellent. And not only the written word but the oral presentation twenty-five years ago permitted Michael Davis, who was the initiator of the graduate program in hospital administration at the University of Chicago, to talk about how he got it started. It wasn't easy, and of course it was the first one; and it was in 1934, hardly a flush period of time. Didn't cost much, I might say; they never invested very much in it for years, but nonetheless starting a new effort was a problem. He thought in many respects it ought to be in the medical school, but the medical school was not fascinated by that idea, so it ended up in the business school, and now I'm sure most people, knowing anything about this form of graduate education, would agree that it is probably a more appropriate locale for the program. Even when I started at the program, not so long ago, there was a great deal of, well, looking-down-nose in the hospital field about programs in schools of business. I should say that by now the type of curriculum at this business school has been pretty well imitated; not that it was the only school that had such a curriculum, but the quantitative skills that were basic to the program from the first are now a part of the curriculum in most of the programs in hospital administration.

I think Richard will talk about organizing and I've said pretty near enough. I thought I had a copy of the publication but couldn't lay hands on it, so I went over to the AHA library and they had several copies that were well thumbed through. I was not one of the speakers, but Ray asked me to write the foreword. Well, I didn't reread everything in there. But any time I come on something I once wrote, I can't resist reading it again. So twenty-five years later I read that foreword, and I thought, say, this is pretty good. And then I had a second thought. I said everything I knew! So, there you are. It's a

good foreword if you have opportunity.

In any event, this forum has gone on. It's been pretty useful. The transactions that I see out on the desk have made their contribution, as I suspect some sort of report for this forum will; so that again I mention that I think it's a great honor that it's called the George Bugbee Symposium on Hospital Affairs.

RICHARD JOHNSON. George, I'd have to say, in all candor, you haven't changed one bit in twenty-five years, and that leads to the conclusion that you're rotting from the inside out. Looking back over a quarter of a century, trying to recall the first symposium with the graduate program, is like trying to remember your first date. You know it was pleasant but you can't remember whether you kissed the girl or not. Perhaps the point to start with, then, is the reasons Ray wanted to hold the symposium. From the close of World War II until the time of that first symposium a number of graduate programs had been started around the country, and he was concerned with maintaining a very select group of preceptors for the residency part of the program. For a few years prior to this symposium, Ray had worked hard to develop a preceptor group that was unexcelled. He believed that the residency was crucial to giving a student the best step possible in starting a career. Because a residency started on July 1st and the number of residencies was growing very rapidly at that period, Ray wanted a group of preceptors who would, at the end of the residency, give the students their first jobs so that the June 30th crush of students ending their residencies and seeking employment could be avoided. There was an understanding with all of the preceptors that they would observe this.

In addition, Ray was concerned that the students receive their residencies in the large, better-known hospitals in this country, so that their early track records would reflect the best credentials available. As a second step Ray conceived the idea of the symposium. Individual invitations were sent to the leading administrators in this country. If they could not attend, they could not send a replacement from their organization. It was a personal invitation. In doing this, he wanted all of the attendants to appreciate that the invitation to attend signified that the program regarded the participants as leaders, because they were mingling with others who were widely respected. It worked well, and those who came were the "Who's Who" of the hospital field.

Well, I can't remember the subject, and George cheated a little by going to the library. I know it would have been a hot topic. Each presentation focused on some aspect and examined it in detail. By the end of the symposium all of the facts would have been thoroughly explored. This was vintage Ray Brown and was typical of his seminars. As I recall the first symposium it was held at Lying-In Hospital. Some stayed there and some stayed at the Windemere, but I remember that what often happened was

everybody frequented the Anchorage, which was the tap room in the Windemere, for the inevitable informal discussions that took place. And the guest list at that time was made up of former presidents of the AHA, former presidents of the ACHA, a sprinkling of University of Chicago graduates, and the rising stars in the administrative field.

I think George Bugbee expressed overall our thinking about Ray at the time of his death. George said, "We've lost a national resource." We sure could have used his insights and his perspectives at this critical stage in the history of hospitals in this country.

Ron, is Andy Patullo here? He's on the list, so I think he's planning to come, weather permitting. Ron had a letter from him, a long letter which I think needn't be read, but he was reminiscing, and he was at that first forum and as the transactions show there was a grant from Kellogg which led to the publication of the forum proceedings.

MR. ANDERSEN. Our first session will be chaired by Reed Morton, associate director of the program, and I think it'd be good if we could have Frank Sloan come up to the podium also.

COST-SHIFTING AND THE HOSPITAL

Frank A. Sloan and Edmund R. Becker

Introduction

Over ninety percent of the revenue for hospitals in the United States comes from public and private third-party sources.[1] Although the predominance of such coverage seems to imply that hospitals are free to thrive in an environment free of external constraints typical of other industries, this inference is only partly accurate. Cost-reimbursement, the most common single method of paying hospitals, has been increasingly linked to stringent definitions of scope and conditions of coverage. Some third-party payers have successfully negotiated contractual allowances, and some expenses are disallowed after they have been incurred. The 90%-plus figure represents the share of hospitals' actual receipts rather than charges covered by third parties. Disallowed payments, bad debts, and free care provided by hospitals appear in hospital books as charges, but not as receipts. Prospective reimbursement plans implemented by some states and Blue Cross plans have extended and formalized some cost-containment efforts already underway.

In view of the dramatic increase in spending for hospital care, especially since the passage of Medicare and Medicaid in the mid-1960s, most observers would applaud serious efforts to limit the rise in such spending. There are, however, potentially adverse side effects when certain payers, principally federal and state governments under Medicare and Medicaid, and Blue Cross plans, act to reduce their own outlays.

First, although reducing "excess" or "unnecessary" hospital utilization and/or hospital inefficiency is a worthy objective, cost-containment efforts may threaten the financial viability of hospitals, especially those serving the poor. Second, rather than reducing their budgets in response to a cost-containment initiative, hospitals may shift costs not covered by one program to others. If so, rather than limiting the rise in society's outlays on hospital care, cost-containment efforts impose a hidden tax on the public. This tax is shared by employees in all sectors of the U.S. economy in the form of lower pay; shareholders, in lost dividends and undistributed corporate earnings; the public, in higher product prices; and hospital patients who pay at least part of hospital charges out of pocket.

The Health Insurance Association of America (HIAA), representing commercial health insurers, has argued that charge-paying patients, many of whom are commercially insured, currently subsidize the care of patients covered by cost-based reimbursement[2]; government payers and many Blue Cross plans pay cost rather than charges. This double standard of reimbursement, by which hospitals charge one group of patients more because another group of patients is not paying its share, is known as "cost-shifting".

Commercial insurers argue that this system of payment is unfair. From their perspective, no payer should have to bear the burden of shortfalls by paying more for the same level of care. Further, when costs cannot be shifted, the resulting financial distress will lead to hospital closing. In contrast, government payers and many Blue Cross plans contend that the reimbursement system is basically fair. They argue that they are simply prudent buyers, paying only the costs associated with their patients. Lower per diem payment is justified because their patients cost the hospital less. Their cost-containment efforts result in reduced total outlays for hospital care; thus all payers benefit from such activities, albeit unequally.

These claims and counterclaims raise some important questions about cost-shifting. This paper addresses these fundamental questions related to the cost-shifting dilemma: (1) Is the differential payment indeed justified on the basis of differential patient costs? (2) Have the cost-containment efforts of a few dominant payers reduced total payments to hospitals? and (3) What part of these savings is realized in terms of accounting costs as opposed to accounting profits?

Past Research

Several studies, sponsored by Blue Cross plans, have investigated cost differentials, between Blue Cross and commercial insurers.[3] The authors typically sampled a number of hospitals based on several characteristics of the hospital, such as size, location, and ownership. They then examined Blue Cross and commercial patients' records from these hospitals to determine cost differentials between these payers, as well as bad debts, averted and incurred. The studies have not analyzed all hospital costs that might result in cost differentials between Blue Cross and commercially insured patients, but only those elements of cost for which information was available and which appeared to be the most fruitful area of investigation, including admitting patients, billing, and credit and collections; working capital; other administrative (accounting, medical records, and processing); patient care (routine nursing, house medical staff, and social services); management services (shared services and provider relations); and community services.

The overall conclusions reached in these studies is that it is from five to thirteen percent cheaper for hospitals to serve Blue Cross than commercially insured patients. These studies, however, have a number of shortcomings. For one thing, they did not consider all sources of differences in costs between Blue Cross and commercially insured patients. A payer may be less expensive on a few elements of cost which the studies analyzed but more expensive on others which the studies did not assess.

Only two studies have examined payment differentials in hospitals across several payers.[4] Miller and Byrne, Inc., examined payment differentials in Connecticut among five classes

of payers: Blue Cross, Medicare, Medicaid, commercial, and self-pay patients. Eight cost categories (routine nursing services, admissions, billing, credit and collection, medical records, social services, working capital, and charity and bad debts) in five hospitals (selected according to size and location) were examined. The authors found that hospitals spent less on the care of other patients than on that of commercially insured patients: for Blue Cross, 4.6% less; for Medicaid, 3.4% less; and for Medicare, 13.6% less. Hospital care for self-pay patients was even less on a per diem basis, by 37.7%.

The second multi-payer study, by Lewin and Associates, Inc., is the only one of these studies not confined to a local level. The authors examined data from 15 hospitals (differing in size, complexity, ownership, and location), five in each of three states. They focused on seven classes of patient cost differences (business office, accounting, medical records, social services, nursing services, working capital, and collection of payment). However, because the sample of hospitals studied was not weighted to reflect the distribution of hospital types in particular states or the U.S. as a whole, the authors offered no single summary measure of overall payment differentials among various insurers. They did find some substantial cost differences among payer classes in all seven categories.

Other studies have dealt with differences in hospitals' routine nursing service expense.[5] A study by the American Hospital Association (AHA), published in 1966, found that elderly patients require more daily routine nursing services than other hospital patients. Partly as a result of this study, Medicare decided to pay a routine nursing salary cost differential of 8.5%.

J. Michael Fitzmaurice conducted an empirical analysis of the relationship between per diem hospital routine salary costs and the proportion of Medicare routine patients for the Health Care Financing Administration. His data set combined Medicare hospital cost reports for 1977-79 with information from the AHA and used the hospital as the observational unit. He considered several alternative specifications, but failed to find a statistically significant effect of the proportion of hospital routine patient days consumed by Medicare patients on per diem routine nursing salary costs. He concluded that there is no empirical foundation for a Medicare routine nursing cost differential. The Fitzmaurice study represents an important advance over most studies on this subject. He used a large, national data base and controlled for factors that undoubtedly influence nursing costs, such as prevailing wage rates and hospital commitment to teaching.

Fitzmaurice's result is not surprising. Although Medicare cases tend to be more complex than average, their stays tend to be longer. Greater complexity means that more nursing services are required; but the last few days of even a fairly complex

episode are not likely to be nursing-intensive. A recent literature review by the Government Accounting Office (GAO) concluded that existing evidence on balance seems to be against the view that hospitals incur higher routine expense on behalf of Medicare patients, but GAO took a more cautious stance on this matter than Fitzmaurice.[6]

Although some of the comparisons of hospital cost by source of payment are interesting, they may also be misleading. Concentrating on one or even a few components does not eliminate the possibility that while the measured component is lower, an unmeasured one is higher and partly, if not completely offsetting. Thus, to assess cost differences among payer categories, one should start with total per diem cost. Even this task is complex since it is difficult to know precisely which variables to hold constant when such comparisons are made. If differences in the bottom line have been established, it may be useful to examine the components of cost. However, any method of allocating joint costs to departments inherently involves arbitrary accounting decisions, and for this reason in particular, it is important to include all cost centers in any such disaggregated analysis.

A recent article by Patricia Danzon has questioned previous work on hospital costs and profits, especially as they relate to methods of reimbursement.[7] She argued that cost-reimbursement recognizes accounting costs but not as profits for payment purposes. Thus, the job of any good hospital business office is to convert accounting profits, not subject to reimbursement, into accounting costs. Further, since overhead is allocated to departments by Medicare (and some other cost-payers) based on the share of department charges incurred on behalf of Medicare patients to total department charges, hospitals have an incentive to boost charges in departments used extensively by Medicare patients above the price they would set if all third-party reimbursement were charge-based.

Danzon's argument demonstrates institutional knowledge of cost-based reimbursement and is a fine application of economic theory to hospitals. However, the proof of the pudding is in the empirical evidence. Based on her argument, one would generally expect higher department costs and a higher ratio of charges to costs in departments used extensively by Medicare patients. In her analysis of laboratory costs and charges with a sample of California hospital patients, Danzon found higher proportions of laboratory charges incurred on behalf of Medicare and Medicaid patients increased costs in these cost centers, but only the Medicaid proportion influenced the charge-to-cost ratio in the hypothesized direction. As the author noted, one reason for the weaker finding for Medicare may be that some laboratory services are provided on an outpatient basis, and Medicare requires patient cost-sharing for such services. Another possibility, not mentioned by Danzon, is that case-mix differences could explain her results. Danzon did not include a case-mix measure in any of her regressions. Whether or not one should explicitly adjust for

case-mix depends on the question being asked, but statistical tests for reimbursement effects on hospital behavior should use an approach for holding case mix constant.

Strange as it may seem, virtually no one has paid any attention to the effect of the distribution of hospital payment sources on total cost and profitability. If, without holding case mix constant, total cost per adjusted (for outpatient activity) patient day is the same for cost- as for charge-payers, one cannot justify a discount to cost-payers on the basis of cost. If, holding case mix constant, the payer mix does not decrease cost per adjusted patient day, but does lower profits, it is hard to argue that reimbursement rules have in fact generally encouraged hospitals to convert accounting profits into accounting costs. Finally, the sum of total cost and profit per adjusted patient day yields total payments to hospitals--charges less bad debt, free care, and contractual allowances obtained by private and public insurers--per adjusted patient day. If the size of the discount affects this per diem payment figure, one cannot argue that every dollar one payer saves by obtaining a discount from hospitals will be fully offset with funds from another patient revenue source, as the HIAA has (at least implicitly) argued in its analysis of payment shortfalls.

Our Study

To investigate this set of issues, we have analyzed data from two national surveys conducted by the American Hospital Association in 1979. We summarize methods and findings here. The complete study has been published in the Journal of Health Politics, Policy and Law.[8]

Data Sources

Our first data source is the Reimbursement Survey. This data-base contains information on hospital revenue and charges broken down by payer source: Medicare, Medicaid, commercial, self-pay, Blue Cross, and other (HMOs, self-insured health plans, and payments from other government agencies), for community hospitals throughout the U.S. The second source is the 1979 Annual Survey of Hospitals. The Annual Survey contains pertinent information on hospital costs, outputs, facilities, and services. We merged data from the Annual Survey with responses to the Reimbursement Survey. In addition to the hospital information, several variables defined for each hospital's market area were merged into the data file. These include county per capita income, county population per square mile, county non-federal office-based physicians per capita, and county general practitioner proportion.

Specification

Our empirical analysis has two major objectives: (1) to gauge the influence of a hospital's payer distribution on hospi-

tal costs and profits, and, (2) holding the payer distribution constant, to determine the effect of discounts on total payments per unit of output, which is defined in terms of adjusted patient days and, alternatively, adjusted admissions. Our cost-dependent variables are total hospital cost per adjusted patient day and per adjusted admission. The adjustment permits us to express outpatient visits in terms of inpatient day equivalents. Profit-dependent variables are the ratios of the hospital's patient revenue to total cost, and total revenue (patient and non-patient) to total cost. All variables expressed in monetary terms have been deflated by an area price index.

All regressions have the same set of independent variables. The regressions include independent variables for government ownership, teaching status, bed size, proportion of adjusted patient days that are outpatient visits, proportion of potential facilities and services available, hospital age, surgical operations per admission, resource need index (case-mix measure), county per capita income, county population per square mile, county non-federal office-based M.D. per capital, county general practitioner proportion, annual wage for other hospital employees, and regional location. Proprietary hospitals are excluded from the analysis.

Findings

Our study addresses three fundamental questions related to the cost-shift dilemma: (1) Is the differential payment indeed justified on the basis of differential patient costs? (2) Have the cost-containment efforts of a few dominant payers reduced total payments to hospitals? (3) What part of these savings is realized in terms of accounting cost as opposed to accounting profit?

In answer to the first question, whether the differential payment is justified on the basis of differential costs of treating patients with particular types of third-party reimbursement, the answer from our empirical analysis is "no". The percent of hospital charges from each of the major payer types does have a statistically significant influence on hospital per diem expense, when our hospital case-mix measure is omitted as an independent variable, but the contribution of the payer distribution to explaining variation among hospitals in per diem cost is very minor. When our case-mix measure is included in the cost per diem regression, the payer distribution variables, taken as a group, do not have a statistically significant impact on per diem cost.

We find that hospitals with relatively high shares of patients covered by Medicare and Medicaid do have higher per case costs on average, holding other factors constant. But this pattern is attributable to a higher length of stay for Medicare and Medicaid patients rather than a higher per diem expense. Based on these results, which are taken from a comparatively

large national sample of hospitals, no payer can make a strong case that its patients are less expensive to treat on a per diem basis.

On the other hand, simple comparisons of per diem cost by payer, which do not control statistically for influences related to choice of hospitals, do reveal substantial differences. Medicaid patients in particular select more costly hospitals on average. One reason is the relatively meager amounts Medicaid pays doctors per procedure; this has meant that many such patients do not have regular doctors. Such patients then are admitted to hospitals where the community physician is not a necessary entry point, namely the major teaching hospital. Medicaid funds may be saved if patients' choice of hospital could be changed. Competitive bidding, which is now being tried in a couple of states, represents one possible approach.

The answer to the second question, have the cost-containment efforts of a few dominant payers reduced total payments to hospitals, is "yes". Put differently, the question here is whether hospitals are able to shift costs from one payer to another and fully recover their costs. We find that they can recover some but not all disallowed costs. Our estimates show that if all payers were to pay the same fraction of charges as commercial insurers, patient revenue per adjusted patient day and total revenue per adjusted patient day would be two and four percent higher, respectively. Patient revenue per adjusted admission and total revenue per adjusted admission would be five and four percent higher. Total payments to hospitals would also rise by about four or five percent.

Using data from the AHA Reimbursement Survey, we have developed estimates of the magnitude of the cost shift, using basically the same methodology as HIAA but in some cases, more direct estimates of the underlying parameters. We find that in 1979 Medicare and Medicaid paid $1,900,000,000 less than their "fair share", and the major part of the shortfall was borne by the commercials. The fair share is based on a comparison of payers' shares of total hospital charges with actual payments to hospitals. If a payer's share of actual payments to hospitals is found to be less than its share of total charges, it is said to have paid "too little", and conversely for payers with a higher share of actual payments than charges. The $1,900,000,000 figure is $1,000,000,000 less than HIAA's, but it is substantial nevertheless. When the cost-containment efforts of non-commercial insurers are taken into account, the $1,900,000,000 amount falls by $200,000,000.

Finally, to the question of what part of the overall savings in payments to hospitals is in the form of reduced cost rather than profit, the answer is that the "discounts reduce profits but not cost". Discounts demonstrate no effect on our cost-dependent variables, but there are statistically significant reductions in hospital profitability.

At first glance, this would seem to be good news because when savings are obtained from profits rather than cost, the quality and quantity of patient care appear to be untouched. However, matters are not so simple. Accounting cost, which is the numerator of our dependent cost variables, does not include a normal rate of return on capital, which is truly an element of cost. Moreover, original cost depreciation greatly understates the true cost of depreciation in an era of inflation. At least part of accounting profit, our dependent profit variables, really represents a cost of capital not captured by our cost variables. Therefore, to the extent that discounts reduce accounting profits, they also reduce payments for hospital capital. In the long run, the amount of plant and equipment available for producing hospital care must be affected. Some experts would argue that there is "too much" hospital plant and equipment, both now and in the foreseeable future. Others take the opposite stance. Resolution of this complex, largely normative issue, however, is beyond the scope of this paper.

Notes

This paper was supported in part by grant no. 1-R03-HS04665-01-HCT from the National Center for Health Services Research, U. S. Dept. of Health and Human Services, to Vanderbilt University.

1. From Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1980", Health Care Financing Review, 3(1) (September 1981): 1-54.

2. See "Hospital Cost Shifting: The Hidden Tax", Health Insurance Association of America, Washington, 1982.

3. The majority of these studies were done by the Center for Health Policy Studies, Columbia, Md. They include "Study of the Hospital Payment Differential Earned by Health Care Service Corporation", October 31, 1981 (report submitted to the HCSC), and reports submitted to the respective Blue Cross plans: "Study of the Factors Leading to the Hospital Payment Differential Earned by Blue Cross of Massachusetts", September 1, 1980; "Study of the Blue Cross Differential at Harford [Maryland] Memorial Hospital", August 1, 1979; "A Theoretical Justification of the Blue Cross Differential in Ohio", April 30, 1979; "Study of the Blue Cross Differential in New Jersey", December 20, 1979; and "Measurement of Hospital Cost Differentials", January 11, 1980 (New Jersey).

4. Miller and Byrne, Inc., "Cost Differential Study: State of Connecticut", April 26, 1977, report submitted to the Connecticut Hospital Association; Lewin and Associates, Inc., "Differential Reimbursement of Hospitals", September 1981, report submitted to the Health Care Financing Administration (HCFA con-

tract no. 600-66-0073).

5. Stanley Jacobs, Naomi Patchin, and Glenn Anderson, "American Hospital Association Nursing Activity Study Project Report", 1966, conducted for U. S. Dept. of Health, Education, and Welfare Public Health Services under PHS contract no. HP 110-235; J. Michael Fitzmaurice, "A Statistical Analysis of the Medicare Hospital Routine Nursing Salary Cost Differential", Health Care Financing Administration, August 31, 1981.

6. General Accounting Office, *Do Aged Medicare Patients Receive More Costly Routine Nursing Services? Evidence Inconclusive*, report to the Congress of the United States, January 20, 1982.

7. Patricia Munch Danzon, "Hospital 'Profits': The Effects of Reimbursement Policies", *Journal of Health Economics*, 1(1) (May 1982): 29-52.

8. *Journal of Health Politics, Policy and Law*, 8(4) (Winter 1984).

CAPITAL ACCUMULATION AND THE HOSPITAL

REED MORTON. Our next speaker is Arthur Henkel, who's a vice-president and managing officer of Kidder, Peabody. Mr. Henkel has been involved in extensive numbers of capital financings for hospitals throughout the United States and elsewhere in the world, has experience working as an administrator in New England, as a consultant, and now as an investment banker. But we are certain that his most distinguished accomplishment was graduating from the program as the Bachmeyer award-winner on a campus full of very capable individuals. Without further delay, Art Henkel.

ARTHUR J. HENKEL. Thanks, Reed. I want to thank Ron, Reed, and Odin for inviting me to speak at the twenty-fifth Bugbee Symposium, and I want to start off with a quote, since we're talking about the future, from a well-known sociologist and sometime movie star. When talking about the future, Woody Allen once said, "The lion and the calf shall lie down together but the calf won't get much sleep."

Keeping that thought in mind, my discussion topic this morning is Capital Accumulation and the Hospital, or Where is Our Security Going? The "our security" in the alternative title does not refer to investors. It refers as much to health-care deliverers of all types as it does to people committing capital to the health-care industry. As many of you would observe, "capital accumulation" is also, perhaps, not quite the right title, since in the past hospitals typically have had to get access to external funds to complete major expansions, renovations, and other capital investments. In the sixties and earlier, of course, there were grants and philanthropy; the seventies were marked by the shift to debt financing of all types, and the question of the eighties, of course, is how are DRGs and other changes in the payment mechanism going to affect access to external funds.

The topics I'm going to be covering this morning are (i) a brief review of the historic methods of access; (ii) the current environment, both from the operations side and the capital market side, and the interaction of the two; (iii) near-term changes and their implications as we see them; and finally (iv) security alternatives: that is, how you as chief executives of hospitals around the country can ensure through your actions continued access to those external funds that have proven so necessary in the past.

As I mentioned earlier, hospitals have always had to use a mix of external and internal funds to meet their capital needs. As Frank Sloan said in his presentation, historic cost depreciation is going to create shortfalls in capital accumulation in any inflationary environment. Only the magnitude of the shortfall is in question under such scenarios. Therefore other sources of internal funds are essential. The "bottom-line" changes referred to earlier this morning are instructive in that many hospitals

are in fact seeing this potential shortfall as a problem and reacting to it by increasing other internally generated funds. Beyond that, non-operating income from previous investments also remains important in certain situations. Even with such actions, other sources of necessary capital still include donated funds and investment funds. However, the topic of my discussion will exclude these external areas as a source and focus on debt-related sources.

As a brief review, what I'd like to do is go over just who are the investors in health-care capital and what are their major investment objectives. These, of course, should give you some thought as to what your own actions will do to impact their desire for your particular debt issue. Pension funds, which are now at a zero tax rate and hence not buyers of tax-exempt securities, do in fact participate in the taxable market for private placements of debt and could be an important source of debt in the future if in fact tax-exempt bond issues for hospitals are somehow limited.

Life insurance companies, which, owing to a lower marginal tax rate, also participate largely in just the taxable market, again have the same potential for change in terms of activity, if tax-exempt financing potentially is limited. Beyond that, such life insurance companies may in fact increase their participation in the tax-exempt market if their tax structure is changed and tax-exempt income again becomes desirable from their side.

Casualty insurance companies, on the other hand, participate both in the tax-exempt and taxable markets. Their participation is quite variable, however, owing to their own profitability pictures and hence the need for tax-exempt income. For example, in 1979, of the new issues marketed in the municipal market, casualty insurance companies purchased in excess of thirty percent of the new issues marketed. In 1981 that percentage had fallen to nine percent, and in 1982 it stayed in the nine- to eleven-percent range. Thus far casualty companies' participation has begun to increase, but it is certainly not at the 1979 level yet.

Commmercial banks are another source of funds in both the tax-exempt and taxable arenas. They participate in two areas: one, discretionary trusts--that is, funds given to a bank to invest at the discretion of the trust officer; and second, for their own account--that is, to bring more of their investment income to the bottom line.

Beyond these participants, managed bond funds and unit investment trusts, which are two similar types of institutional investors, have been very active in the municipal market. As a matter of fact, in 1982 they were the only continuous source of institutional investor in the market.

Finally, of course, individuals purchasing directly from

their brokerage firms have changed their participation dramatically. In 1977, only twenty to twenty-five percent of the new issues marketed in that year were purchased by individuals. Last year it was seventy-five percent.

Backing up for a minute, the bond funds and the unit investment trusts are, in effect, individual purchasers of portfolios of securities rather than one particular security, as are discretionary trusts. So if you combine those you would say that basically 1982 was an individual-purchaser year for municipal securities and may well be the mode in the future as well.

In aggregate there is a large volume of investable funds generated and available for participation in capital markets. However, despite these seemingly large sources of funds, it is important to recognize the scope of the potential difficulties that we see for health-care institutions.

Most of you from Chicago can picture the Sears Tower. Imagine that the Sears Tower is a solid stack of dollar bills--every little nook and cranny going up the 1450 feet is filled with dollar bills. That volume of dollars would not equal one percent of the estimated total capital requirements for all segments of the American economy in the 1980s. As a matter of fact, the health-care industry itself would have to have eight or nine of these Sears Towers filled with dollars to meet what is projected for its own capital needs. In aggregate, the so-called infrastructure needs of the various municipalities, the private corporate needs, utilities, and of course the federal government have been estimated to require in excess of two trillion dollars during this decade. Naturally, that means a little bit of competition for those scarce investor dollars.

In 1979 Kidder, Peabody projected capital for the health-care industry for the eighties as part of a Bureau of Health Facilities task force. We developed a total aggregate need, depending on a particular assumption related to closures, of between 158 and 193 billion dollars over the decade. We have adjusted this estimate to reflect a lower inflation rate; originally we had used a total inflation and technology change factor of thirteen percent per year, which, for those of you who remember your finance courses, compounded over the decade would bring a big number to the fore. Substituting an eight percent factor, which seems to be more in line with today's experience, and, assuming a fifteen percent capacity reduction, you will get a projection of 124 billion dollars over the decade. The two pie charts are pretty much in proportion. The one on the left, of course, is the lower projection with a fifteen percent reduction in overall bed capacity. That implies, of course, some closures and/or mergers, with capacity reduction as a result. The chart on the left, of course, is the original projection of 193 billion dollars.

Some of you may debate--matter of fact, we've had our own

debates with others who subsequently have done their own projections--the inclusion of working capital as a capital need. Our own feeling is that people operating hospitals in fact, for the collection reasons that Frank mentioned previously, use a fair amount of bottom-line and other funds to meet working capital requirements. These proportions, of course, would change under the reduction scenario with a lower inflation rate, with plant taking up sixty-six percent as opposed to seventy-one percent of the total projected needs. However, it is still a substantial number, in excess of 80 billion dollars just for plant and equipment over the decade. To put that number in perspective, in the whole decade of the seventies debt financing totalled somewhere on the order of thirty billion dollars.

This structural problem is exacerbated to some degree by the capital markets and their behavior over the past several years. Volatility has become the name of the game, and investors' doubts and uncertainty have caused them to look to safer securities. The yield for treasury obligations has fluctuated dramatically in recent years. The gap between short- and long-term rates has changed as well.

This kind of volatility makes investors nervous and consequently makes them think about what we in the trade call "fleeing to quality". That is, in weak markets, markets where uncertainty about the general financial well-being of the overall economy is a keynote, the investor will seek haven in assets that he or she deems to be safe relative to other investment opportunities. Consequently, to the extent that health care comes to be viewed as an "unsafe" investment, owing to continuous or unpredictable changes in regulation or other factors, the hospitals will have to face three problems. First, net interest costs for borrowing will go up as attracting investors becomes harder and a bigger risk premium is required; second, security provisions associated with any debt issue might be tightened to protect the investor, and this in turn will have a result of reducing operating flexibility for the future; and finally, in the worst case, the bonds or other form of debt may not be marketable at any price. The third case sounds like an Armageddon-type scenario, but I can point to specific instances in the past three years when this has already happened; that is, when lower-rated issues were perceived to be too risky and other factors just drew no particular investor interest whatsoever. Consequently, they had to be withdrawn from the market with no transaction being completed.

Most investors, especially individuals, rely heavily on the rating services to help determine their own perception of quality. Quantitative factors affect rating potential and include such things as leverage (i.e., how much in debt will you be relative to your projected overall asset base?) and income-generating capacity (how much can your utilization suffer without your being unable to pay your obligations?). Beyond that, qualitative factors also have a major impact: management structure and experience; history, in terms of reacting to previous

health care. Presumably a major insurance company will insure the tax-exempt bonds of VHA member institutions to enhance their marketability. However, I am aware of a charter member of VHA that was recently turned down under such an insurance program even though it had received an A bond rating. The issue was marketed solely on its own merits. I might add that depending on fee structure, it may not be worth the premiums for an A-rated institution to seek such insurance.

Regardless of the cost/benefit, this anecdote indicates to me that there's a lot of potential there, and there are a lot of very strong hospitals in the United States that are members, and if they're willing to give up some of their autonomy, they might, in fact, enhance their access to capital. However, as my illustration indicates, being a member of VHA does not guarantee anything at the moment, other than that you can pay dues.

ANDREW KORSAK. In the insurance industry there is a tendency to frown upon the formation of groups formed merely for paying group health insurance. My first question is, in view of this, would investment bankers similarly frown upon groups of rural hospitals formed just to obtain capital, number one? Two, if "yes", what types of associations of rural hospitals would the investment community smile upon?

MR. HENKEL. The question basically draws the analogy between group purchasing of health insurance and rural hospitals' grouping together in some form of association, cooperative, whatever, to gain access to capital markets. Implied in the question is the fact that the average size for a BBB hospital, which is the lowest rating that most firms will market and below the rating level that most institutional investors will purchase, is about 200 beds. Now, you and I know that many hundreds of rural hospitals are in the below-200-bed category. What are they to do? The answer to that question varies with the type of association that develops. Is there in fact a management core that develops out of a group of ten, let's say, 75-bed hospitals, or do you just have the bookkeeper and CEO at each one getting together to form a board that votes on a committee basis? If the latter case pertains, you don't really have very much. Let's assume, for example, that each of those ten hypothetical hospitals generates $300,000 or less of depreciation-throw off every year. What kind of pooling of security will they agree to? In other words, using $300,000 as a base number, will the rural cooperative's members each throw $20,000 annually into a special security fund to enhance its capital access? That is, will such funds be used to raise equity when needed by each of the cooperative's members, and/or to secure further the debt that each of its members may incur?

From the individual member's viewpoint, to the extent that it doesn't have any major capital needs for fifteen years, it must consider the possibility that by the time it wants to utilize this limited security pool, its forty-nine compatriots have

already exhausted its value. So, depending on their structure, these consortiums may help access. The distribution of ratings in the multi-institutional organizations is much higher than the overall hospital average. Only two single-facility institutions have been rated AA in the past two years: the Rhode Island Hospital and the Cleveland Clinic. Most of you understand how special the situation of each of those facilities is. I wouldn't guarantee that a rural hospital cooperative would get an AA rating, but it might bring its members to an investment-grade level, which means that they would get access to capital where little exists now.

Thank you very much.

REIMBURSEMENT METHODS AND THE HOSPITAL

REED MORTON. Howard Berman is a group vice-president of the American Hospital Association. Howard is a graduate of the hospital administration program at the University of Michigan, a fact in which he takes considerable pride. Howard is co-author of the standard text in hospital financial management--from which one now hears that Paul Samuelson has written the Hospital Financial Management of economics. And Howard is an individual who has the highest expectations of performance from the hospital administration profession and has been instrumental in trying to bring about a reimbursement system that will demand the utmost from the administrators.

HOWARD BERMAN. They tell a story around the country about a hospital administrator who'd been on a year-long trip out of the country. He'd been completely out of touch with the news and events of the past year. However, on his year-long sabbatical he'd had time to think and he came back all fired up. He was ready to go. He had developed what he thought was a fail-safe strategy for turning his mainstream community hospital into a major tertiary-care teaching center. He came back and told his staff about his plans, and they listened politely . When he was finished, he saw that they weren't as enthusiastic as he was about it, and he was surprised, because in the past they had talked about the same kind of plans as he had. So he asked them what was troubling them. And they told him what had happened in the payment arena in the last year. And he listened quietly, and he asked some questions to assure himself that he wasn't being made the butt of some bad joke in poor taste. Then he thought for a moment, and finally he told his staff that that was all very interesting, and that it seemed to him that it forced two kinds of major conclusions: first, that he should never have gone away and left them in charge, it just didn't work; and second, that the future wasn't going to be the way it used to be.

And in looking at payment methods and the hospital, which I guess is my topic, the key point for all of us to realize is--and really, if you leave the symposium this year with nothing else, you should realize--that the future has changed, that the future isn't going to be the way it used to be. The events of the past several months have made it clear that we're living in an interesting time in general, and particularly in the health field. Hospitals are confronted today not only with demands for change--that's not unusual; you can have a nice smooth curve for change--but also with demands for transition. We're not only being challenged to perform better but also, at the same time, we're challenged to do more. Moreover, we're being asked to harmonize those discordant pressures and at the same time to provide a product that adds greater value to our communities, and to do more in terms of value than ever before. We're being asked, and we're being expected, to do this now and also to do it into the future.

Now, looking into the future is always an interesting kind of task. As you know, some people, psychics, do it for a living. Let me share with you some of my favorite futurist predictions. There's a man from Tennessee who predicted that by 1980 social drinking would virtually come to an end. Now, I can only presume that what he had in mind was that we'd limit our drinking to medicinal purposes. I'm not sure, though, that that's what he thought, because he also predicted that by 1980 physicians would join the ranks of faith-healers. Another psychic, who goes by the name of Criswell, predicted that by 1980 the city of New York would be under water; by 1981 Montana would be the penal state, with all the criminals who are given criminal sentences being sent there--anybody from Montana here? I guess they don't know about the University of Chicago in Montana; that's the only explanation, right?--and that by 1982 a dying planet named Bullanon would come so close to the earth that it would shift the poles and bring the rising of the lost continent from the seabed; you've all noticed that. He also predicted that by the end of May of this year all the women in St. Louis would lose their hair, and so far the last prediction has come true only for me.

Now, if you're losing confidence in Criswell, fear not, for by 1985, he predicted, Texas will be split into three separate states. Another predictor named Vaughan, who is with Psychic Magazine, predicted that there would be no presidential election in 1980, and that by 1980 the water level around New York would rise, making it uninhabitable. (New York may be uninhabitable, but I don't think it's for that reason.) I could go on if we had more time. From what we've heard so far, a couple of things seem to be clear. First, either psychics don't like New York, or New York is eventually going to be in real trouble, and I'll leave that to Art to work out for you in later questions. Second, even psychics can't predict the future with any better degree of accuracy than you or I.

With respect to hospital financing and payment, I'm not sure that I could do a much better job of predicting the future, particularly since our world began to change very significantly last August. Moreover, it changed again last month. As the man said when he came back from his long trip, the future ain't what it used to be. So instead of trying to look into some sort of murky crystal ball, let me use the precision of hindsight and talk a bit about hospital payment and talk about it in terms of what happened, why it happened, what it means, and what it means with respect to implications for hospital management and resulting management strategies.

What happened? Without getting bogged down in technical details, in August of 1982 the Medicare payment system changed. That by itself is interesting, but it's not necessarily significant. Medicare has changed often in the past. In fact, if you look at its history, Medicare changes almost every two years. It changes almost with every Congress. What makes the '82 changes significant--what makes the '82 changes different--is that they

reflect a fundamental change in the economic incentives confronting hospital management. (Joel and I were having a little conversation in the back, and I think he's going to say a lot more about that later.) Prior to 1982, Medicare paid hospitals on a retrospective cost basis. Certainly there were "tinkering" kinds of controls, and those controls were installed to try to contain cost better. However, those attempts to contain cost were best known for their arbitrariness and for their ineffectiveness; they didn't produce results. The best or perhaps the most flagrant example of these tinkering controls is the Section 223 limits. Section 223 represents a classic sort of mismatch between good intentions on one hand and operating reality on the other. In its attempt to determine reasonableness statistically (which is what Section 223 tried to do), it confused equity with uniformity. By its very design, it used arbitrary mathematical decision rules in a circumstance where, instead of arbitrariness, prudent, weighted judgment was what was needed.

Now, those tinkerings aside, the payment system was one that essentially paid hospitals more, the more the hospital spent. Many, with the wisdom of today, question and even ridicule that kind of an approach to payment. I suggest, however, that the ridicule doesn't reflect any great degree of insight. Rather, it evidences a lack of understanding of the fact that we exist on a continuum of constant change; and it also shows that we didn't understand the fact that we've seen in this country, in the last two-plus years, a shift in our national goals, a change in our national priorities. Cost-based, retrospective payment, the idea that can pejoratively be characterized as simply meaning "if you spend more, you get paid more" is, if your national goals are to expand the health care system, a near-brilliant design for a payment system--if your national goals are to expand the healthcare system. If your national goals are to overcome the financial and geographic barriers to care that plagued this nation in the 'forties and 'fifties, then not only does cost-based payment make good sense, but cost-based payment is also good public policy.

Recently, however, our goals have shifted. Make no mistake about it: they've changed. We've moved away from an emphasis on issues of access. We've moved away from our concern over social welfare, to a point where we now seemingly place a higher priority on matters such as defense spending. And we may not agree with that shift; I know that I don't. My guess, however, is that with the aging of the population, with the advances that are continually being made in medicine, sooner than some people think, we'll see another change in our priority-setting: a change back to a more direct emphasis on social welfare concerns. I think we can see the beginnings of that kind of change, if you pay attention to the current congressional debate over the budget.

That, however, is another issue; it's an issue for another day. The reality of today is that our national priorities have

changed and that there's going to be relatively less money available for the poor. There's going to be relatively less money available for the old, relatively less money available for Medicare, and relatively less available for Medicaid. We may not agree with those decisions, but let us, even while we try to change those decisions, not deny or ignore this new kind of reality: an economic reality of limits, which requires that payment systems must also be changed. Payment systems must be changed in the sense that their implicit and their explicit incentives have to be brought into congruence; they have to be melded with the newly stated national goals. In the case of hospital payment, this means that retrospective cost-based payment has to be replaced. It has to be replaced with a prospective, fixed-price payment approach, one similar to the way the rest of our economy works, with price or total amount of payment set in advance. It means that risk, as opposed to being passed through (as it is under cost-based retrospective payment) must be used in the hospital economy as it is in the rest of our economy: as a motivator for improved efficiency; as the director for improved effectiveness.

1982 Medicare changes begin to effect just that kind of change in the payment system. They move the payment system from having an emphasis on access to having an emphasis on cost-reduction. Now the mechanics of doing that were fourfold. First, it essentially established the payment ceiling based on a target rate. Second, it moved the unit of payment from total cost to a per discharge basis. Third, it recognized case mix as a legitimate factor in either increasing or decreasing rates of payment per discharge; it did that by redesigning the Section 223 limit mechanism. And fourth, it allowed the hospital to keep, if its costs were less than price, part of the difference between its cost and the target rate price. Conversely, if its costs were higher than the price, it had to absorb the loss. Now stripping away some of the "Rube Goldberg" character of the mechanics, the 1982 Medicare changes, because that's how Section 223 was structured, resulted in a DRG-driven cost per case system, with financial rewards and penalties based on economic results. The 1982 changes were known as "TEFRA", the Tax Equity and Fiscal Responsibility Act of 1982. Now at the time of its passage, it was understood that TEFRA was just a first step on the way to something else. It was part of the evolution toward a prospective pricing system.

The next step in this process just took place. Included in the Social Security amendments of 1983 was the next kind of evolutionary change in Medicare payment to hospitals. Beginning for fiscal years on or after October 1, 1983, hospitals will be paid essentially a DRG price per case. TEFRA will last for only a single fiscal year--regardless of the institution, it'll last for a single fiscal year. And it'll be replaced by a system that is going to pay on the basis of a particular price for each type of DRG case treated by the hospital. What has happened is that the hybrid approach of TEFRA has been replaced by a payment

system that's price-based.

Now there isn't time to discuss the details of the Medicare prospective pricing system at length; therefore let me just try to highlight its major differences from TEFRA. First, it sets price for each DRG rather than setting just an average cost by a target rate. Second, it severs, it breaks, the traditional relationship between Medicare revenues and Medicare costs. Third, it puts hospitals fully at risk for differences between cost and price. And fourth, it eliminates Section 223. Now clearly we're moving into an uncharted area here. Obviously, further refinements, further technical amendments will have to be made, even though legislation recognizes that it has to continue to evolve, because the legislation calls for about eighteen different studies and reports. Even so, we've taken a step forward. We're better off now than before, because our financial performance can now track our operating performance. Well-managed institutions--all well-managed hospitals--can now generate Medicare operating margins. And the arbitrary, capricious penalties of Section 223 have been eliminated.

Given that that's what happened, why did it happen, and why did it happen so quickly? The fundamental reason it happened goes back to what we just spoke of: a change, a shift, in our national priorities. The administration is both a part of and a reflection of that kind of shift in priorities. They made it clear from the outside that they weren't satisfied with the rate of increase in hospital expenditures, and that they were going to try to do more about it than just lamenting it. In fact, doing something about health care costs became one of their priorities.

Their immediate answer was TEFRA. It was understood that TEFRA was a first step, a compromise step. But even as a compromise it was a step forward. It was a step forward in that it established a target rate; it provided some short-term Section 223 maneuvering room, even though it substantially ratcheted Section 223 down in the out-years. But most important, TEFRA required that the Secretary [of the U. S. Department of Health and Human Services] develop and report back to the Congress by the end of 1982 a prospective payment program. At the same time that this was going on on the hospital payment side of the equation, the Social Security Reform Act was also moving ahead. The two became joined in 1983. The obvious reason for joining the two together was simply that it became apparent that part of the solution to protecting the financial solvency of the Social Security trust funds rested on changing the incentives of the hospital payment system so that cost-containment became a real management and operating priority. It became real by economically recognizing the cost of production, by rewarding effective performance, and by penalizing poor performance.

Now conceivably, we could have fought the linking of prospective payment to Social Security. If we had done that, we might have been successful. But that success would have put us

on an unknown and unclear track. Our only certainty if we had done that would have been the fact that Section 223 would not only continue to ratchet down but also do so on a more intensive and on a more pervasive basis than before. Essentially, then, because of the certainty of the Section 223 penalties, we had no choice as a field but to take the opportunity that was available. If we were to have any chance to solve the problems we still had, we had to begin to move. We had to take the only real opportunity that was available for proceeding beyond TEFRA to the next step.

Now given that decision, the legislative process went quickly, because the Social Security Reform Act went quickly. The ultimate result obviously reflects a series of compromises. You can't expect, nor should we ever expect, anything more than that from our political process. Really, it's the building of those kinds of compromises that are the strength of our political process; and it's something we should nurture, because it reflects the variation, the diversity, that is part of our national strength. Even as a compromise, however, the 1983 Medicare prospective pricing legislation is better than TEFRA, just as TEFRA, in the changed national priorities, was better than cost-based payment with Section 223 limits.

What does it all mean? Most simply it means that our world has changed, and that we're going to have to change with it; that we're going to have to continue to change with it if we're going to continue to prosper. And let's not for a moment deceive ourselves into feeling that we haven't prospered over the last forty years. The going may not have always been easy, but the results have clearly been positive.

It also means that on a relative basis there will be less money available. Don't forget that from the federal government's perspective, the goal of all this was to shrink, to contract, the rate with which the Medicare pie was growing. So let's realize that there'll be relatively less money available.

It also means that the operational definition of "cost-containment" will change. It moves cost-containment from the realm of management aesthetics to that of necessity. It makes it an operational reality. It changes cost-containment to a necessity of operations because cost-containment now becomes the means of producing financial viability. Relationships with third-party payers can also be expected to change.

Let me go back over this ground; but let me do it from another perspective. Let's view it in terms of implications and management strategies. The notions of change and of less money should be self-evident and clear. The notion of cost-containment becoming an operational reality, while probably also self-evident, deserves some elaboration. First, we're going to have to pull up a couple more chairs to the management table. We're also going to have to rethink and review our production

functions, and our product lines. We're going to have to reconsider what our market, our community, wants and how it wants it. And then we're going to have to provide it in a way and in a location where it's convenient for the community, the buyer, not for us, the seller. We're going to have to remember the difference between buyers and sellers and the fundamental market truism that the buyer has no guaranteed or franchise-given, continued loyalty to the seller.

We're also going to have to convince all our employees and staff that they're a vital part of the solution. They're a vital part of the answer to keeping the hospital financially viable. Now the convincing should be easy, because it's true. The hard part is going to be to make our rhetoric and our actions consistent. Finally, we're going to have to move: to be aggressive, to be innovative, not only in terms of what we do and how we do it but also in terms of a new willingness to take risks, and particularly the risks associated with new kinds of ventures.

Let me expand on a couple of these points. First, more seats at the management table. The seats go to the medical staff and the trustees. They go to those two groups because now more than ever before, they need to be brought into the management formula. They need to be brought in as productive elements, not just as bystanders, not just as observers.

Physicians have to understand the pivotal role under a DRG or any other cost per case system that their admitting and treatment patterns have on the financial health of the hospital; they also have to understand the direct link between the financial health of the hospital and the ability of the hospital to maintain the kind of practice environment--staffing, equipment, physical facilities--that they want for their practice and for their patients. This time, in contrast to ever before, the physician can't play one hospital off against another, because the same payment situation and the same incentives apply in all hospitals. Therefore physicians are ready to become part of the team. The key and the need is to bring them in, in a productive manner; to show them that their self-interest is best served through the common effort and through their direct decisions; that they can help make and keep the hospital not only viable but, more important, the kind of institution that they want to be associated with, the kind of institution that their patients want to be hospitalized in.

The trustees also now need a seat at the management table. This time the seat is more figurative than literal. Trustees should not be involved in day-to-day operating decisions; in fact, that kind of level of involvement would be counterproductive. Rather, the trustees as never before need to understand the changes that have taken place and the implications and requirements of those changes for businesslike behavior. The trustees also have to understand that the future will require a break with the past, a change from the past, in that different

decisions and different decision-making discipline will be needed. And the only way for them to be able to understand that is through their education, through their substantial involvement in the institution.

In a fixed-price payment environment, the pursuit of efficiency also takes on a new meaning. It changes from the aesthetic endeavor to a vital part of the management equation. Efficiency combined with physician practice patterns determines whether the cost per case will be less than or greater than the price. Efficiency and practice patterns determine profit or loss. Practice patterns relate to physician involvement. Efficiency relates to productivity, product-line decisions, and the community's demand for services. Productivity is a people issue. The key lies, again, in enhancing our treatment of staff, in making them feel that their contribution is important and that therefore they are important.

Product-line decisions are a bit of a different matter. To be productive, or to be efficient, you obviously have to have a critical mass of volume. In a price per case world, you have to generate the volume necessary to achieve a profitable level of operation, or you have to cut out or cut back the product line, or you have to make a decision to subsidize. Whichever way you choose, you're confronted with a new and different kind of decision from in the past, a business decision; a decision that requires that the medical staff be part of the decision team, that the medical staff be at the table to help make those decisions.

Now my guess is that the typical strategy of first choice cwill most often be to attempt to increase demand. That means you have to know your market. You have to be close to your market. And you have to provide services that the market wants in a way it wants them. It means providing a product that is perceived as having value. If you provide service, if you provide value, then the rest of the financial picture will generally take care of itself. The strategy of second choice, which will, I argue, in time probably become the dominant strategy, will be to reshape the product line: to give up some products; to take on some others; to follow a kind of wobbly track of strategic advantage. Here again the pivot of the strategy and the management decision is the community. To make a product-line reshaping strategy work, you still have to focus on service and value. It all comes back to essentially the same thing: increase service, increase value; and if you accomplish that, the financial bottom line most often takes care of itself. That's the lesson we've learned over and over again from the best-run companies in America. It goes back very much to what Art was saying in his Henry Ford quote.

Finally, we'll need aggressive management behavior, an action-orientation. The precursor event here is the preparation of trustees. The leadership for that obviously has to come from management. The need here isn't simply for blind action. The

need isn't for action solely for the sake of movement. Rather, it's for action to achieve a vision. It's for action to achieve the vision of a hospital in terms of what it can be, what it has been, what it still has to be to its community. We have to realize through our leadership, and perhaps sometime through our courage, the vision of the hospital as a community resources; the vision of a hospital as a human-services organization. Now it should also be recognized that as a by-product of this, private payers are also going to benefit, for the price pressures on their products will be reduced. Thus in the traditional kind of sense, the private payer can benefit from the changes that the public sector has wrought on us.

Stopping there, however, leaves the story sort of unfinished, because it begs the question of non-traditional implications for the private payer. From the private payer's perspective, the real significance, and the ultimate effect, of the changes that are taking place may well lie in the effects they have on the continued relevance of the product, on the business that the private payer is in. When you moved to a fixed-price, per case payment system, you unavoidably change the risk contours in the hospital landscape. You shift risk from the private-payer underwriter to the hospital. When that happens, when you make that shifting of risk, then other things will also happen. And you have to expect that eventually the hospital will try to reduce, to minimize, its risk by bringing together, by integrating, operating and underwriting risks. And as that happens, the traditional product of the private payer becomes obsolete.

To survive, then, the private payer is going to have to develop a new partnership with the hospital; it's going to have to develop new products. The private payer has to rediscover old partnerships, has to rediscover a whole set of original partnerships. And those partnerships stem from the simple fact that the private payer cannot exist without the hospital. It's the hospital that provides the real product that the private payer sells. Therefore, as the hospital changes, the private payer is also going to have to reach a new risk-sharing accommodation or a new partnership with that hospital. And to effect that, the private payer is going to have to develop new products, products that better integrate delivery and financing. Now whether those products are vouchers, preferred-provider organizations, limited-choice plans, or capitation systems, I'm certainly not smart enough to know. In all likelihood they'll be those things and other things. They'll be a combination of ingenuity and imagination, and only time will tell what the ultimate answer is. To the private payer, however, the greatest threat of what's happened lies in a slowness or an unwillingness to get on with the process of creating these new relationships and these new products. If the private payer is unwilling to act or is slow to act, I think we can expect to see the hospital move into this non-traditional sphere of business.

The times ahead will be interesting. We have to realize

that we're entering into a new era. And it's not going to be a trouble-free era. In fact, it'll be, in retrospect, one of the most difficult times of our lives. I also think it'll be one of the most challenging and exciting times in the management history of hospitals. We're at a beginning. And as with all human endeavors, beginnings are the hardest part of all. Thank you.

REACTOR PANEL, Thursday morning, May 19, 1983

GEORGE BUGBEE. Howard, are you implying that physicians will not have multi-hospital appointments?

HOWARD BERMAN. No. What has happened in the past is that one hospital has tried to assert management practices with its medical staff; those physicians have always had the opportunity to move their practice to another hospital, where the management wasn't under the same pressures and incentives. What's changed now is that Medicare has applied the same pressures, the same incentives, the same system across the landscape, so that if you want to move from one hospital to the other, you can obviously still do it, but the incentives will be the same, so that you can't play off one against the other, because if you're a high-cost DRG provider, you're a high-cost DRG provider, regardless of which hospital you're practicing at.

ART HENKEL. Frank [Sloan] makes the same mistake that some of the HCFA people make, saying that Medicare and Medicaid, the cost-based system, has been a boon to raising capital and hence that would be a reason that you don't get return on equity or anything else. I can universally dispute that by pointing to the fact that we have data in a data-base of twenty billion dollars' worth of hospital revenue bonds, and can show figures that would even pass Ron's muster in terms of statistics, that the higher the percentage of Medicare and Medicaid revenue any hospital has, the lower its rating potential and actual rating, and hence the higher cost of capital. There's a fellow from HCA who once told me that he was trying to make a case that Medicare owed him more money because in fact it caused him to borrow more than he otherwise would have to. He didn't get too far with that, but he gave it a shot. But in the non-profit area it's just absolutely true that the cost-based system and the impact that it has on financial performance does in fact act as a detriment to raising funds, not as a golden safety net, which the people at HCFA used to--well, I suppose, do--think. And we've had debates on that before. So I'm sorry Frank isn't here to debate me on it; but it's not a cheap shot, really.

ODIN ANDERSON. I have a question to ask Art about the number he quoted of a hundred billion dollars, a hundred and fifty billion dollars for capital need over a ten-year period. None of us has any idea how much that is, of course. On what basis were those estimates made? What were the criteria?

MR. HENKEL. The method we used in developing those numbers essentially assumed a twenty-five year asset life; it looked at when assets were added to the health care industry since 1946, and made a presumption that in twenty-five years a replacement would be generated on a one-for-one basis.

MR. (ODIN) ANDERSON. You need to replace a hospital in twenty-five years? Is that your estimate? They last longer than

that, don't they? I've seen some around.

MR. HENKEL. You may not want to be in one of 'em, though. That was the estimate; if you look at the average life of assets overall that are reflected on a balance sheet, it's somewhere in the 25- to 28-year range, on balance. And then of course you have the code changes, which on top of everything else may make something...

MR. (ODIN) ANDERSON. Do you have any idea how much it would cost to replace our entire hospital stock today if it just disappeared?

MR. HENKEL. No. Well, we were talking about . . . well, I'll tell you what that [the hundred fifty billion dollars] was, and then you can extrapolate from that. What that reflected was an absolute replacement on a one-for-one basis of twenty-five percent of the assets and a renovation of another approximately twenty-five percent. So if you wanted to double it, to three or four hundred billion dollars, depending on what scenario you chose, that would be where you'd come out. We didn't do that, because that was a little too extraordinary a situation.

MR. (RON) ANDERSEN. Howard, you talked about ingenuity and creativity on the part of the hospital, in response to a case-based method of reimbursement. I think one of the biggest issues has to do with the different methods by which the physician is still reimbursed, and you talk about bringing the physician in, in a more direct way, to managing. What do you expect to happen with respect to the hospital strategy, the physician response, and possible changes in reimbursement of physicians?

MR. BERMAN. The nice part of faculty asking questions is that they make 'em so long; you can then take the easiest part. So let me take the easiest part, Ron. What do I expect to happen with physician reimbursement? As part of the 1983 legislation, the Secretary [of HHS] is instructed to examine how physicians can be paid under a DRG basis. So other people are taking a look at that same kind of issue. As I look into my crystal ball, I don't see much happening that will be effective. They may tinker with it; they may change it. But unless you can have a monumental shift in the attitude of organized medicine with respect to assignment and non-assignment, it isn't going to do anything other than (probably) taking more money out of the patient's pocket. Now, what other parts of the question would you like?

MR. (RON) ANDERSEN. How are you going to convince the physician that it's in his or her self-interest to behave in a way that is most efficient for the hospital given the case-based reimbursement?

MR. BERMAN. It would be a mistake to think it's going to be easy. There are a lot of old habits that are going to have to be unlearned. Similarly, it's a mistake to think that there's a

cadre of hospital managers that are out there, eager to go out and talk to their physicians. One of the things we find as we go across the country and talk to people is that there are a lot of folks out there that are really afraid to begin to crack that nut. But what we found is that there are examples of where administrators and physicians have been brought together. Don Oder can tell you about probably one of the classic examples in the country at his place [Rush-Presbyterian-St. Luke's]. They do exist. And what it requires, though, is not window-dressing involvement, but real involvement of the physicians. Hillcrest--down in Tulsa, Oklahoma--Steve Landgarten, vice-president for medical affairs; part of the management team; corporate title; salaried, talks to us and tells us how they have worked with their department chiefs to bring them in, to involve them in management decisions.

What we find from that kind of example and from others is that where you've done the basic homework, where you've explained what is happening, when you've gotten over the hurdle of "They can't do that to us!", the physician then comes to understand, and often comes to understand more quickly than some management people, the management implications of that. And they [physicians] come to understand that if they can start to change their practice patterns, if they can knock off a day, half a day, on certain diagnoses, that that's money that's going to be available to that institution and that money can go into new technology; that money can go into new services; that money can go into their pet projects. And you follow the same thing that Adam Smith outlined for us: selfish interest; common interest. But it takes a lot of work, up front, to teach, in the most benevolent sense of the word, so that they understand the pressures that the institution's under.

MR. HENKEL. Ron, I'd like just to add to that. This is an anecdote. I was flying in yesterday, and the guy across the aisle from me was reading the <u>Annals of Cardiology</u>, which I don't think people read unless they have to. And he read that for about the first forty-five minutes of the flight. The remainder of the flight--this is a Seattle-to-New York flight--he was reading a twenty-page tome on DRGs and how they will affect the practice of cardiology in his area, written by someone--it was a reprint and he didn't know--it was provided by the local medical society. He spent as much time, if not more time, on that as he did on whatever new knowledge he was getting out of the <u>Annals</u>. At least the guy is reading it; what he's going to do about it, I don't know, but . . .

JOHN IMHOFF. Well, I'd like to follow that up. I'd like to know what <u>we're</u> going to do about it, too. I come from a non-SMSA hospital; you could say it's a rural setting, a one-hospital-in-town situation. And we have the additional misfortune of having a fiscal year that starts on October first, so it didn't take us long to get into TEFRA. While we don't know precisely what our cost per case is [applause from nearby], we

have come pretty close to $2275 per case. Speaking to the hard issue, the new dual Cambridge pacemaker costs $5300, and it didn't take a whole lot of managerial acumen on my part to conclude that that didn't fit into the cost per case situation very well.

There are multiple appointments for the doctors; there are hospitals for them to be appointed to at reasonable distances. Some of those services are provided simply because you're the only provider. It's quite apparent that pacemakers will operate at a deficit of $163,000, and hence we can't do it. I'm kind of curious, when we do get into the DRGs, and again, we'll be a leader with that come October first, if we won't find--and I'm sure we will; in fact I think it's been documented in New Jersey--that there'll be many other instances similar to this, where we'll find, perhaps for the first time (I guess you could say to our good fortune), that we'll have to decide whether the loss leader is sufficient to keep us going or whether we ought to divest ourselves of it.

But it seems to me that we have a potential for some pretty major re-adjustments in terms of how the people who are the consumers are going to get 'em. And there's going to take a lot of adjustment, I would guess, from the consumers' point of view, and a lot of understanding (perhaps a lot of education there as well) as to why they can't get their care in a setting where they've been accustomed to it, and may have to go two or three hundred miles, and their families and so on to visit them as well, in order to find themselves treated for their particular conditions in the most cost-effective place. It seems to me that bodes well for some pretty significant complications as well.

DICK JOHNSON. I was fascinated, Howard, with your comments, because under DRGs, the median is going to be applied, and since the physician triggers the diagnostic and treatment procedures, in effect what that means is that half of the physicians, approximately, in this country will be practicing over the rate. That means, therefore, that if you use a bell-shaped curve you normally could get the top 25% off, you're going to get right into the middle; and I wish you'd comment on what you think the medical staff problems are going to be.

MR. BERMAN. There's an implicit assumption in what you've said, Dick, that I think it would be helpful to make explicit. Three or four years down the road, if the '83 legislation is not amended, hospitals will be paid a single price per DRG and that price will be the national average for that DRG. Year one, the price is 75% hospital-specific, 25% regional. To the extent you keep the DRG price hospital-specific, you avoid the problem that Dick outlined. To the extent that you make it an average price, you are saying to the hospitals in this country that "We're paying you an average price; therefore you have to look and behave like an average hospital."

There are 435 representatives and 100 senators each of whom have in the district a hospital that each thinks is special, and doesn't think is an average hospital. If you pay an average DRG, you're saying to Rush, "We want you to look like average, and average is something like Glenbrook." Rush can't do that. University of Illinois hospitals and clinics can't do that. Nor should they. It's part of the refinement process, but it's the refinement that's going to be needed to avoid exactly the problem you're putting your finger on. But that's again another fight for another day. Now that day is coming pretty quickly; but that hasn't escaped our attention.

MR. MORTON. We have time for one more question.

REED REYNOLDS. [Inaudible; notes taken at the meeting state that Mr. Reynolds asked whether we would see an increase in physician ownership of hospitals because of DRGs.]

MR. BERMAN. I don't know why we would. I think that we will come pretty quickly--and maybe Art has some data to prove it--I think we'll come pretty quickly to recognize that bricks and mortar and inpatient acute-care beds are not cash cows, that the profitability comes from using the critical mass of centralized resources to provide other than inpatient acute care. So I would be less concerned about physicians wanting to own the bricks and mortar, more concerned about them wanting to get into competition with the hospital in terms of the less capital-intensive services. But if you can con your medical staff into buying the bricks and mortar, and they'll pay you in cash, take it.

MR. MORTON. Thank you very much to the reactor panel; thank you for your attention and participation this morning. We have lunch planned now, and we should be beginning about a quarter after one with Joel.

DIAGNOSIS-RELATED GROUPS AND COST-CONTAINMENT

RICHARD FOSTER. It's certainly been a pleasant and informative time at Chicago and I've enjoyed it very much. I'm grateful to the people I've had a chance to work with, and I'm also grateful to have been associated with this symposium during the time that I have. Speaking of people who have made a contribution to the program, the first speaker for the afternoon is someone who needs little introduction. To most of the people in this group, Joel May is not only a graduate of the program, but also a former faculty member, indeed, a former director, of the program in health administration. He will be talking to us this afternoon about what many people have hailed as the prototype of the new Medicare reimbursement system in New Jersey; and I won't presume to say very much more, because whatever I think Joel is going to say, he always comes up with an angle on it that I didn't anticipate. So I'll simply turn it over to him and look forward to his remarks.

JOEL MAY. How many of you know what "DRG" stands for? In the first draft of the program for this meeting, my speech was entitled "Diagnostic-Related Groups and Cost Containment". I called the program offices and said, "It's 'diagnosis', not 'diagnostic'." In an article in the current issue of Health Affairs, they are variously called "diagnostic-related groups", "diagnostically related groups", and "diagnosis-related groups". And we have a newspaper in New Jersey that seems to have an editorial policy to call them "diagnosis by related groups".

When, in 1978 and 1979, our administrators in New Jersey were gearing up for this system, they called it "Dastardly Reimbursement Gouge", or "DREGS". But after the first year in our system, which includes specific prices for each hospital, based on the relationship between the hospital's average cost and the statewide average cost, and includes allowances for uncompensated care, working cash infusions to bring the hospitals up to speed at the beginning of the system, and a lot of other bells and whistles that are not present in the federal system, they looked at their bottom lines in 1980 and they said, "Wow, this is a 'Down-Right Gift'!" But as time went on and the rates began to do what Howard Berman this morning called "ratcheting down", the downright-gift attitude went away. In 1982 and 1983, it hasn't seemed so much like a downright gift any more. However, in trying to get their organizations ready for this system, hospital administrators in New Jersey realized, and I think correctly, that it is a "Desirable Reorganization Goad". If you consider this system as one that presents to you as a manager a whole new set of incentives and one that provides you as a decision-maker with a whole new set of information, you'll begin to get the point of what I want to say.

Diagnosis-related groups are described in the literature as "statistically stable" categories of patients grouped on the basis of length of stay, which are also "medically meaningful" in

the sense of being clinically similar. The independent variables used in creating the categories are primary diagnosis, procedures performed, presence of co-morbidity (secondary diagnoses clinically related to the primary diagnosis), age, sex, and discharge status. They were developed using a combination of analysis of variance and medical input judgment, and represent a categorization scheme containing 467 categories, which are mutually exclusive and collectively exhaustive.

In the institution, each patient is assigned to a DRG category using a computer-based algorithm called "Grouper", which takes as inputs six independent variables and makes an assignment accordingly. In New Jersey each hospital was provided with this software so it could make the assignments. I have not heard of any similar plan at the federal level. (In the Medicare system, we'll be using 356 of the 467; that is because the DRGs related to newborns, the DRGs related to maternity, pediatrics, and so on, aren't relevant.) The prospective pricing arrangement assigns a specific price to each one of the categories, and that is what the hospital receives regardless of length of stay, number of tests performed, etc. It is a "price per case".

I want briefly to review with you the way the prices will be set under the 1983 Social Security amendments. First of all, all hospitals except children's, psychiatric, rehab, and long-term-care hospitals will be included. The exclusions are for one of two reasons: either, as in the case of the children's hospitals, they tend to treat a particularly severe case mix, and therefore averaging them with everybody else appears to be inappropriate; or, as in the cases of the psychiatric and rehab, the precision with which the diagnosis can be made, or the predictability of the amount of treatment required, is so poor that it isn't fair to average the hospitals.

The law provides special treatment for sole community providers, public hospitals, those with high volumes of Medicare or low-income patients, and what are defined as "regional referral centers". However, those things have not been defined yet in regulation. "Public hospitals" are pretty clear. "High volumes of Medicare or low-income patients"--how high is "high"? And what is a "regional referral center"? These are decisions that will be made by the regulators, not the legislators.

There will be separate calculations for urban and rural hospitals, but again, we don't have a clear definition for what is urban and what is rural. We have a provision that the rate calculations will exclude capital costs, which will be passed through until 1986, at which time the Secretary [of the U. S. Department of Health and Human Services] will promulgate regulations for how to treat them. Direct and indirect costs of education will be passed through, and there are no plans to change that in the current law. And there'll be an allowance for hospitals re-entering the Social Security system, as they're being required to do. Finally, rates are adjusted for the 1982 TEFRA

provisions.

Those are the basic provisions. They will proceed to calculate a national average cost per DRG and a regional average cost per DRG. Using what is called the "MEDPARS tape", which is a sample of all Medicare discharges for 1981, they have cast those patients into DRGs based on the medical record information available on that tape--and pause for a minute to think how bad the medical record abstract information on your Medicare submissions was in 1981; how you didn't pay any attention to the accuracy because it really didn't matter--then. The average cost of caring for patients in each DRG is then computed on a national and on a regional basis.

Having made those calculations, HCFA will then, for the years '81 to '83, increase them each year by the percent equal to the actual cost increase for hospitals across the country. From '84 to '85, the increase will be based on the HCFA hospital "market basket" plus one percent. The HCFA hospital market basket is a combination of price indices for lots of different inputs for hospital care weighted by their relative importance as inputs. And to that will be added an allowance for medical technology. The law requires base-year neutrality adjustment for 1984. Now, "base-year neutrality" is a Republican term for what the Democrats call "cap". Base-year neutrality essentially means that in 1984 we're going to adjust these rates so that, after all these things have been taken into account, total outlays are not any higher than they would have been under the old rules.

Beginning in 1986, the law says that the Secretary will determine an increase factor "ensuring adequate compensation for the efficient and effective delivery of medically appropriate and necessary care of high quality". The Secretary will do that based on the advice from a commission appointed by the Office of Technology Assessment, which will advise her or his successor about changes in technology, changes in production processes in hospitals, and so on that ought to be taken into account in setting rates for future years.

All of this, then, is adjusted for wage levels in state and SMSA, and as a result, you end up with what is called "regional or national cost per DRG". But the prices you'll receive will not suddenly be based entirely on these averages. There is a schedule for phasing the system in. In year one (your fiscal year beginning after October 1, 1983), 75% of your reimbursement will be based on your own costs. The other 25% will be based on a regional cost per DRG.

In the second year, half of your reimbursement will be based on your individual experience and, of the remainder, 75% will be based on regional and 25% on national average costs. Now, that mix--50% hospital-specific, 37.5% regional, and 12.5% national--approximates the way the rates in New Jersey are paid. The rates in New Jersey, as I've said, are a combination of the hospital

actual, state average, and regional adjustments for wages. And so, if you cast the rates that way, you would have something that approximated the New Jersey system's sensitivity to individual hospital differences.

In the third year, 25% of your reimbursement will be based on your actual costs and the other 75% is fifty-fifty regional and national. And then, in the fourth year, your fiscal year beginning after October 1, 1986, 100% of your reimbursement for Medicare will be based on the national average cost of caring for that DRG.

Now, for those of you who are wincing, I predict that year four will never be reached. I think that as this comes into being, the legislature will get impatient because it's going to take until 1985 or 1986 before you'll begin to see an effect. And as we get further down the line, as Howard Berman pointed out this morning, some big teaching hospitals will be threatened with closure. The legislature will re-think some of this and perhaps stabilize around the second- or third-year pattern. I do not believe that anybody in this room will ever get a check from Medicare that is based 100% on national average cost per DRG.

This, then, is prospective price-setting. And it creates altogether new incentives for the hospital. Under retrospective per diem reimbursement, the incentive is to increase the number of cases treated, increase the length of stay, increase the intensity of service, increase the amenity level, and increase the scope of services offered. We aren't all that concerned with efficiency of operation, because it's cost-based; we don't really care what we pay for our input prices, so if the prices go up, it doesn't bother us a whole lot; we're eager to invest in new teaching programs. Those are the kinds of incentives that have existed in our field for the past twenty years.

Under prospective, per case reimbursement, you still have an incentive to increase cases treated, because the more cases you treat, the more prices you'll be paid; the more admissions, the higher the reimbursement. But you have an incentive to reduce your length of stay, because given a bed stock, the shorter the length of stay, the more available beds, and therefore the more opportunity to admit people. And even if you don't have the opportunity to admit more people, you have an incentive to get people out sooner, because you can save the incremental costs, the supply cost, and so on of caring for them. You have an incentive under prospective, per case reimbursement to decrease your intensity of service; that is, for any given DRG, if you can get away with one fewer x-ray, or one fewer lab test, or one fewer nursing hour, you're a little better off. There is also, under prospective, per case reimbursement, an incentive to reduce amenities.

Pausing just at that point, I might tell you that recently in New Jersey a medical examiner in Ocean County went to his

local newspaper and said that he personally knew of people who were dying within days after discharge from the hospital because they had been discharged too soon. Our Medical Society, in response to that, has established a hotline that anybody, physician or layperson, can call to point out cases where this has happened. The Commissioner of Health has argued that medicine is a profession, and physicians, as ethical professionals, wouldn't do this no matter how much pressure was placed upon them. Incidentally, when the medical examiner who brought the whole thing up was asked to produce a single example of this happening, he was unable to do so. The point is that in general there is a concern that length of stay and intensity of service have been decreased too much as a result of this.

There is an incentive under prospective, per case reimbursement to increase the measured complexity of our case mix. Let me explain that. If we chart more completely and more carefully, as we have every reason to do under this system, we will, on the average, have measurably sicker patients, a measurably more complex case mix. There is also an incentive to identify which of two or more alternative medically justified diagnoses is more or most profitable, and, when an opportunity exists to choose between (or among) alternatives, to choose the more (most) lucrative one. These actions will have the effect of increasing the measured complexity of your case mix. However, within a DRG, you have an incentive to decrease the complexity. That is, having found a DRG that pays well, you'd like to find as many people who suffer as minimally as possible from the conditions associated with that DRG and admit them.

And so you have a incentive to decrease complexity within the category but to increase the complexity of the categories taken as a whole, subject to their profitability. You also have an incentive to decrease the scope of services offered, and an incentive to increase the efficiency of operation, which should be pretty obvious at this point. You're interested in paying the lowest prices possible for inputs. You're not at all interested in investing in new resources, as you once were, unless a resource tends to be uniquely associated with a DRG that pays well. And you may eventually have to cut back on teaching programs. In New Jersey we do, because we don't get reimbursed for these as a pass-through. You will be for the time being.

What you will have from a management perspective under this system is 356 product lines that you're producing in your institution. And you'll quickly begin to realize that it is no longer as important as it once was to think about meals served or pounds of laundry processed per FTE, or any of the departmental efficiency measures that we've been using all our professional lives. What will become important is, "What does it cost to produce an appendectomy?" You'll begin, I believe, to start to manage your institution, not by ancillary departments, but rather by clinical services. And you'll begin to look at your chiefs of clinical service as your departmental managers who run a series

of production lines and decide what goes into their production processes.

How should you proceed to maneuver your institution into this world of new incentives and approaches? First of all, you'll want to do an analysis of length of stay and occupancy by DRG. You'll want to find out how to measure up in terms of those averages. Reimbursement per DRG is based on the mean length of stay for that DRG, so it's important to know whether you are above or below that length of stay. Hospitals with exceptionally long lengths of stay for Medicare will have problems, as will those with large Medicare populations and limited ability to shift costs. They need to know what those problems are, and they don't know until they start thinking about length of stay and occupancy.

You also have to emphasize education: education of management and directors; education of medical records personnel, finance, medical staff, and community. Those were all mentioned this morning. Some of those are probably more important than others, and I think I'd put medical records and medical staff at the top of my list. Another very important thing is to develop a data-merge capability. You won't be able to forecast revenues (net or gross) in your institution accurately until you can merge medical records and billing data, until you can quickly and easily do cuts of your data from the medical records information to the billing information and back again. Very few hospitals can do this.

You'll probably want to appoint a DRG coordinator; almost all the hospitals in New Jersey have done so. The ideal DRG coordinator is typically out of nursing or medical records, with the personality, the intelligence, the curiosity, and the communication skills necessary to raise the questions, to develop answers to the questions, and to test those answers on the medical staff and others. It is an important position, and it's important to identify someone in the institution to be the nexus for all this kind of information and communication and education and stroking that needs to go on. You'll probably want also to establish a DRG committee, which consists of medical staff, nursing, finance, medical records, management, and trustees. I don't know what the right constituency is, but think about what would work best in your institution given the facts that (a) the medical record department is now determining your revenue, not the finance department, and (b) the physician has to be involved in the decision-making process on a patient-by-patient basis, in capital investment and other resource-allocation decisions.

Obtaining the understanding, cooperation, and involvement of the medical staff is most important. It is crucial that you develop communication mechanisms with the medical director, the director of medical education, the clinical chief, the UR-quality assurance director. A question frequently raised is, "How do you get the physicians' attention?" If the system doesn't really

affect physicians financially, and if they aren't concerned with the hospital's bottom line, how do you make them begin to co-operate and work with you on this? I don't know the answer to that yet. I do know that in New Jersey they are paying attention. And the only explanation I can offer you--it's a horseback explanation but the only explanation I can offer you--is that once these kinds of communication channels are opened, and, more important, once the kinds of information that this system produces become available--when on a doctor-by-doctor, DRG-by-DRG basis they can look at each other's behavior--you begin to get a collegial reaction, essentially a peer review, a self-policing reaction, that says, "That one is doing it differently than I; I wonder if I should be more like that one."

We have hospitals in New Jersey that produce physician-specific profit-and-loss statements, so that each physician knows each month how much he or she made or lost the hospital. Now, that shouldn't matter, but they compare themselves with one another! I don't know the exact mechanism, but I can tell you that in New Jersey, doctors--not all of them, but a significant fraction of them--are paying attention. And that's all it really takes to get change in the organization.

You'll find it essential to enforce compliance with medical record requirements. The face-sheet non-completion rate dropped 33.8% in New Jersey in the first year. There isn't a hospital in New Jersey that isn't actively enforcing the suspension rules. Why? You want a five- or a six- or a seven- or an eight-day billing cycle. You've got to have the face sheet completed within 48 hours after discharge in order to get the bill out in a reasonable length of time. And if the face sheet isn't completed, you can't cut a bill.

One approach developed in New Jersey, which is, to me, an interesting and apparently a very productive approach, involves hiring extra medical record people to go up to the patient units and read charts, as they would during the coding process. If they see anything in the body of the chart that isn't yet reflected on the face sheet, they leave word with the head nurse, who passes the word on to the doctor. This on-going monitoring on the nursing unit not only gives you quicker and probably better medical records; it also allows you to do something that a few hospitals have begun to do, and that is, to do prospective assignment of DRGs. Assign the patient to a DRG within 48 hours of admission, so that you can guess what the revenue will be and make some decisions about regimen of care.

I mentioned the individual profit-and-loss statement by physician. There are many other ways of communicating with the medical staff. You may want to inform them about their individual practice profiles. You may want them to know how many lab tests, x-ray tests, prescriptions, and so on they used in producing a particular kind of DRG, and also provide information comparing them with their colleagues, so that they can see how

well they fit in with the norm and how they differ. They can then begin to discuss which is the more appropriate pattern.

A number of management options present themselves when one is dealing with this system. One is doing nothing, and a few of our hospitals have done nothing, and some of them are hurting and some of them aren't. It's easy to do nothing under the federal system if your Medicare load is less than 20% and you have a fair percentage of commercially insured and self-pay patients to shift costs to. So doing nothing is not fatal, but I think it's highly risky.

Some of the most progressive hospitals have begun to use DRG groupings in a strategy grid. This concept appears to have originated with the Boston Consulting Group, and is also employed by Ernst & Whinney. If you think of your business as somehow related to a need-demand vertical axis and a profitability horizontal axis, you can place each DRG into one of four quadrants. If it's up in the upper right-hand quadrant, it's a profitable line of business for you; you do it very efficiently and make money at it. Furthermore, there's a high need in the community. That's a winner, and when you're making resource allocation decisions and staffing decisions you want to back your winners. If it's down in the lower left, you're losing money on it, and there really isn't much need for it. That's a loser, and probably you want to cut your losses as quickly as you can without rocking the institutional boat too much. On the lower right are what can be called "cash cows". Those are services for which there really isn't much need but that are highly profitable; an example might be cosmetic surgery. Finally, in the upper left are the services that are highly needed in your community, but you can't make them profitable no matter how hard you try. In twenty-five words or less, the management strategy followed is "Back your winners, cut your losers, and use your cash cows to subsidize needed services and to allow you to do community service."

Developing marketing programs on a DRG or clinical service-specific basis follows directly. We are beginning to see what amounts to _de facto_ regionalization in New Jersey. Hospitals are beginning to emphasize (programmatically and financially) what they can do most efficiently and to de-emphasize what they can't. As a result, physicians and patient will gravitate toward hospitals that are efficient in providing the care and services required--an important ingredient in any possible cost-containment benefits that may be attributed to the system. We're seeing mergers among institutions for the same reason.

Art Henkel this morning mentioned only one remaining proprietary hospital; we have, however, had several hospitals sign management contracts with proprietary firms in the last couple of years in order to try to manage under this system. A recent issue of the _Federation of American Hospitals Review_ contained interviews with the CEOs of many of the big chains, and they all

thought that this per case, prospective reimbursement would benefit them since it rewards good management. In this system we have a handle on what we can manage.

The title of this speech is "DRGs and Cost-Containment". Cost-containment under prospective, per case reimbursement is possible if there is discriminate or indiscriminate belt-tightening in order to maintain profitability in your institution. If both management and medical staff respond positively to the incentives that the system creates--the kind of thing we've been talking about during the last few minutes--and if investment, staffing, product line, and organizational design decisions are made on a business basis, you can make this system work both from Medicare's point of view, in terms of reducing the rise in hospital costs, and from your point of view, in terms of the profitability of your institution. It's important to remember that from Medicare's point of view none of this is really necessary for the success of the system. Medicare is planning to pay the average "reasonable cost" of the care for each patient, and will continue to define "reasonable" and to dictate the rate at which these costs/prices will increase. Thus, the cost-containment objectives of the approach can be accomplished at the macro-level independently of the hospital response.

However, your institution's financial and organizational health will be threatened if you don't respond. While it may seem to be an advantage in the short run, I see as a danger in the longer run your continued ability to shift costs from Medicare to other classes of payers. I hope that more and more states will apply for a waiver that will allow the extension of this per case reimbursement system to all payers, because as long as the cost-shifting possibility exists, all the negative results that Frank talked about this morning will continue to occur.

Finally, the positive results with respect to cost containment and even the future of your institution will be seriously threatened if we continue to place too high a priority on quality and need considerations vis-a-vis profitability and efficiency. I opened by saying "this is a whole new world" and I think my assertion about quality vs. efficiency and need vs. profitability encapsulates what I think the new world is going to be like.

CASE REPORTS FROM TWO INDUSTRIES ON COST-CONTAINMENT

RICHARD FOSTER. There were several allusions this morning to the emphasis in the symposium on the private-sector response to changes in government activity in health care. In the next part of the symposium we focus much more intensively on that, with three case studies of active programs in the private sector, which in this case means people who are not primarily providers of health care. I'm reminded of the confusion about what's private and what's public. But we do have individuals who have been active in corporate cost-containment efforts in three very active programs to speak with us, and if they would all come up now, we'll take a little bit of time to hear from each of the three of them. The first speaker is Aija Ronis, and she is with Honeywell Corporation in Minnesota and has past experience with HMOs in Milwaukee before coming to Minneapolis. She'll be talking about the activities at Honeywell.

AIJA RONIS. Thank you very much. I was asked to talk about our experience, and HMOs particularly, so I'll focus on that, and towards the end of my pitch I'd like to talk about a couple of other cost-containment strategies that we've engaged in. Honeywell first offered HMOs in 1978, and we've got some data on the experience. After three years of HMOs, we decided to do a study and find out how has this affected us: are we saving money; are our employees satisfied; is this a good cost-containment measure? So three years later we gathered some data. The enrollment rate was 30% the first year, 45% the second year, and 62% the third year; and now about 70-75% of the people are in HMOs. We have 16,000 employees in Minneapolis, and that's where the study was done, so my remarks primarily refer to the Minneapolis work force.

When we offered HMOs it was a collective decision by both management and union. We have a very strong union. Out of 16,000 employees, 8000 are represented by the Teamsters. So there was support for HMOs on the parts of both labor and management. We had extensive communication about this. We developed our own film; we had department meetings; we had booths set up with all the HMOs--we offered six. (There are now about seven HMOs in the Twin Cities; and there are a lot of things called "PPOs" that are popping up, but at that time we didn't have anything like that.) We had about a two-month promotion period where we tried to familiarize all of our employees with HMOs, and we had both group and staff models that we offered, so there was hardly an employee that didn't have an HMO physician near home. The largest HMO, Physicians' Health Plan, had about 2,000 physicians, so almost any physician in Minneapolis was part of Physicians' Health Plan. And there was also an IPA of sorts in St. Paul, although we don't really have a whole lot of employees there. The point that I'm trying to make was that accessibility was a key factor in the high enrollment that we had. Also, we are self-insured, and all of the HMOs in '78 and also in subsequent years have cost us significantly less than our indemnity

plan had.

Between '78 and '80, hiring was big. We hired about three or four thousand employees during those three years, and they were all new hires. We found that out of the new hires, about 80% of the people went to HMOs. So that's another reason why we think our penetration was so high. In subsequent attitude surveys we found that the satisfaction with HMOs was very high. People like them; it was very convenient for employees who had families; it was a place where they could get all their health care taken care of. There was a very high level of satisfaction. And many employees joined HMOs because they didn't have to change their doctors; all they had to do was to change the paperwork and all the other extra effort that went into being a member of an indemnity plan.

We had our first experience with adverse selection when we offered HMOs. This was before I came to Honeywell, so I couldn't tell them it would happen. We found when we looked at our data that generally the hourly work force is an older population and more at risk, and these people generate more medical claims dollars. And there was significantly more HMO enrollment in our salaried work force than among the hourly employees. As an example, in '78, about 23% of our hourly people joined HMOs, and about 41% joined HMOs from the salaried ranks. This kind of two-to-one ratio persisted pretty much throughout the three years that we tracked the data. We also looked at employees' claims experience before HMOs were offered, and we looked at the groups that chose HMOs and at those that didn't. We found that claims among the people who did not choose HMOs were significantly higher than claims among those who did. So the higher-risk people weren't as quick to jump into HMOs. This was true both in the cost of their claims and in the days [of hospitalization] per thousand.

Why did this happen and how did we deal with it? One of the reasons we believe we had such adverse selection is the culture of the hourly population versus that of the salaried. The salaried work force was more knowledgeable in the whole concept of changing medical care, and the hourly work force was probably slower to accept change. They did not join the HMOs at as great a rate. And also they were the higher-risk group. We're negotiating now with the HMOs. Initially they did not allow people on disablity, or on leave for workers' compensation or illness, to join the HMOs. Automatically you get a high-risk group that's screened out. So now we're working on having our HMOs accept people who are on leave; this would significantly minimize adverse selection.

One other reason to which we attribute adverse selection is that people who have significant medical claims are unwilling to change insurance systems; they want all options open to them, and they see an HMO as a kind of restriction on their ability to go to Mayo, to go to Boston, or wherever, to get medical care. We

might have minimized this adverse selection if we'd priced differently. We pegged the company contribution to the highest-cost plan, to our indemnity plan, minus fourteen dollars. The reason for the fourteen-dollar subtraction was a contractual agreement with the union. So for most of the employees, HMOs were free, or cost just one or two dollars a month, whereas for the Blue Cross-Blue Shield plan, they had to pay a little more, but it was not a sufficient difference for them to want to go into an HMO. Now had we pegged our contribution rate either to the least costly HMO or to an average of the HMOs plus the indemnity, the HMOs would have cost our employees more, and that would have minimized some of the adverse selection that did take place.

We're looking at flexible compensation packages now, and the one thing that we're looking at most carefully is how we're going to price the medical plan. Since medical is the benefit that the employees value more than any other benefit, even including pay, it wouldn't be a good employee relations tool to peg our contribution to the lowest-cost plan. They would see that as a takeaway. We should peg it to something less than the highest-cost plan. That would negate some of the tremendous adverse selection that can take place.

Despite some of the negative experience we've had with HMOs, we still believe that they're a cost-control mechanism. There are national data that show that if you look at an employed population that joins an HMO, their days per thousand will go down when they're in the HMO. Since we have a fairly low turnover among our employees, those employees that are now in HMOs--the young, the healthy, and the new hires--they're going to age and start incurring claims, and they'll be subject to the cost control provision that most HMOs offer. It's a great recruiting tool for new hires: people who come to Minneapolis don't have to worry about where they're going to find medical care; they have these HMOs all over the Twin Cities, where they can gain entree into the medical care system.

But what about the other thirty percent we have in Blue Cross-Blue Shield, who are our higher risks? We've been very active in the Twin Cities community in developing, with other corporations, a utilization review program that includes preadmission screening. Before an employee is admitted, we screen to determine whether the admission is appropriate. We also review length of stay and ancillary services. So that's one measure that we're fairly hopeful will perform some measure of cost control on the population under the indemnity plan. We're also involved in--and we encourage our other divisions outside the Twin Cities to become involved in--medical or business groups that deal with controlling medical costs. We're active in the Midwest Business Group on Health. There's a business group in Phoenix we're involved with and one in the Twin Cities area.

One of our high-cost areas has been mental health and chemical dependency, and we're very actively involved in developing

employee assistance and preventive programs in that area. I'm not sure whether I can quantify the cost control in wellness and lifestyle change programs; I've got positive feelings and negative feelings about these. But they're a tremendous employee relations tool, so we're sponsoring various kinds of programs in wellness, lunchtime programs on nutrition and weight control, blood pressure screening, and that kind of thing, to get our employees thinking that they can manage their own health fairly effectively.

MEMBER. Does the firm plan to get involved in PPOs?

MS. RONIS. We probably will. The last I heard (and the number changes from day to day), there are going to be about four PPOs in the Twin Cities before the end of the year. We are looking at the PPO very seriously. I personally think that it's one extra measure of cost control. If you look at the legislation that's coming, and some of the implications of TEFRA, there's going to be an incentive for employees to choose lower-cost plans, especially if we go into flexible compensation, where employees can design their own benefit package. There are probably many employees out there who would like a lower-cost medical plan so that they can buy more vacation, more pension, more life, or whatever. So, yes, we will be.

MEMBER. Do you see a big difference between your operations in Minnesota and those in other parts of the country?

MS. RONIS. Yes, we've got variability in our work force. The Minneapolis work force is probably the most costly. It's the place where we have the greatest concentration of older, hourly employees; that's where the corporation started. Fort Washington in Pennsylvania is another one; but even that's not as bad as Minneapolis, so that I think the differences have more to do with the demographics of the population than they do the HMOs. There's no place other than some of the west-coast plants--and we've got fairly small plants out on the west coast--where there's a lot of HMO activity, and we haven't done a really good job of looking at our data in terms of medical claims. We're trying to build a data base, but we really can't tell you what the medical claims were like in Denver versus Phoenix versus Minneapolis. But I know the demographics are different.

MR. GINZBERG. Senator Durenburg said to Ms. Davis, about fifteen months ago in Congress, that despite all the HMO stuff in Minneapolis, the cost structure had not shown any change. Would that be true today, or not?

MS. RONIS. Well, I think it's right. I mean, our medical costs in Minneapolis have been increasing at rates that aren't too different from anywhere else--although there have been those who have said the rate of increase is less in Minneapolis than it is in other parts of the country. But now we have about thirty percent of the Twin Cities population in HMOs, so that still

leaves seventy percent out in the fee-for-service sector. But that may not be a great enough number to affect your medical costs significantly. There's a lot going on in the Twin Cities, and costs should be going way down and they're not. I think part of the recessionary economy has some effect on it; there're so many variables that there's really no good answer. I don't know.

ANDREW KORSAK. What are your patient days per thousand running among retired employees?

MS. RONIS. We don't have any data on retired employees.

MR. KORSAK. Are they on the plan?

MS. RONIS. Yes, they can buy a supplement, but we have not been able to get that kind of data out of our carrier. The days per thousand of the non-HMO population was about 1100. I can give you HMO days per thousand, but we've been to all the HMOs and asked them for Honeywell-specific data, and we weren't able to get it. HMOs are trying to get better data on their individual groups, but we haven't really been that successful. The only HMO on which we have reasonably good data is Physicians' Health Plan, which is the IPA, and for that I'm just going to give you a ballpark number, because I don't know what it is exactly: that may be between six and seven hundred days. But we really have a lot of homework to do; and so do the HMOs, to give us better information. I'm on the board of the largest HMO in the Twin Cities, and it's been very successful, but the data that this HMO has been able to gather on its own employees' utilization are lacking. So they're working hard, trying to build a better data system, and I don't think this HMO is any different from the others. Okay, well, thank you!

MR. FOSTER. Thank you very much. Our next two speakers come from an area that doesn't have quite as high an HMO penetration rate, but I gather they haven't give up on cost-containment in that regard. Our first speaker--our first next speaker--will be Harry Malone, who's with Continental Bank in Chicago.

HARRY MALONE. I think the first thing you'll see is that Chicago is different from the Twin Cities, and we do not have the same type of penetration in HMOs. However, I think Continental Bank is unique in Chicago. I'd like to talk to you on two topics: first of all, Continental Illinois Corporation's HMO experience; and second, some of the things that we're doing currently in the cost-containment arena and some of the things that we are considering.

Employees of Continental Bank are geographically concentrated in Chicago. We have about 13,000 employees world-wide, and 10,000 of them are in Chicago. Approximately 9600 of those employees are eligible for our medical plan. Currently 22% of eligible employees belong to one of the five HMOs we offer.

We started offering HMOs in 1974, when we offered Intergroup to our employees. Unlike many companies, we didn't take the approach of doing what's minimally acceptable under the law. We were very enthusiastic about the HMO concept, and we promoted it heavily to our employees. We were enthusiastic about HMOs for the following reasons. There was a large concern in our senior management about the access to high-quality health care for many of our employees, inner-city employees specifically. There were numerous cases of employees using hospital emergency rooms as primary-care physicians. We also liked the appeal of the preventive concept and the health-promotion concepts that HMOs were offering at the time. We felt that those were very positive things, that we needed change. We also thought that HMOs had the proper incentives for health care cost-containment. For these reasons, we promoted HMOs very heavily with our employees; we had small group meetings, numerous articles in our house newspaper, and a long lead period of two or three months in promoting Intergroup.

In the first year, six percent of our eligible employees enrolled in the HMO. That pales by comparison to Honeywell, but in Chicago, I think, it was fairly good. As we went along, HMO enrollment increased by about two percent a year; and then in 1978 we decided to offer all of the HMOs in Chicago that were federally qualified at the time. Our reasons were that we still believed very strongly in the HMO concept and we knew that there were geographic areas in the city and the suburbs that did not have access to HMOs through Intergroup. We wanted a higher penetration by providing access to more of our employees. We also felt that we could gain something by promoting some competition among HMOs for our employees.

Prior to '78 HMO enrollment in Intergroup was approximately eleven and a half percent of eligible employees. When we offered the four additional HMOs, enrollment grew to just over fifteen percent. And, interestingly enough, Intergroup also gained that year; they did not lose members to some of the other HMOs. Again, we did promote the new HMOs very, very heavily.

Based on these results from 1974 through the present, we have some reactions to our HMO experience. One of the things is, we're not sure if our original enthusiasm for health promotion and the preventive aspects of HMO has been proven correct. Our opinion is that HMOs have become pre-paid treatment centers for illness. They haven't promoted health education as much as promised. The HMOs have recently assured me, however, that they will be getting into health promotion very heavily in the Chicago area, and we hope we'll see some payoff in that in terms of the overall fitness and health of our employees.

Another interesting observation is that unlike those in the Twin Cities, the HMOs for our employees in Chicago have always cost more than our insured plan. Continental contributes 80% of

the cost of the insured plan and employees contribute 20%. We extend that same contribution amount (80% of the insured plan) to the HMO. So an employee who elects an HMO is paying more than he or she would pay to belong to the insured plan. This has been the case since we first offered HMOs.

Community rating hurt our plan, since we do not have a hazardous work environment with related kinds of illnesses. This keeps our costs lower than some of the industrial companies'. Despite the cost differential from HMOs and the insured plan, we found a relative price insensitivity on the part of our employees: that is, as prices have increased and the differential between the insured plan and the HMOs has grown, we have not lost enrollment. There has been an increase in employee contributions to our HMOs every year, and a steeper increase in recent years after community rating. The enrollment in all of our HMOs has steadily increased; and recently it's remained at approximately twenty-two percent. We have not found that a lot of people have left the HMOs because of the price, even though some of them have been very expensive.

We attribute this to a few things. One is that the bank hires a lot of young professionals, many of them from other locations, and, as was the case with Honeywell, we find that the ability to obtain a ready-made physician, if you will, at an HMO has been attractive to these new employees. We've also found, in looking at our employee population, that a lot of young people with families tend to go into our HMOs; again, high utilizers, so it's been a little bit of the reverse from the Honeywell situation.

One of the reasons, we find, that people stay with the HMOs is that they tend to develop the same kind of relationship with the HMO center that they would develop with a fee-for-service physician. As a result, we don't find a lot of shifting between HMOs in our open enrollment periods. Typically a shift between HMOs occurs only when an employee moves and it's not convenient to go to the old center. We find that a few people do leave the HMOs because of the prices, but that's more than offset by more employees enrolling for the first time.

I would now like to discuss some of our other cost-containment efforts. First, in 1981 we switched our insured medical plan from a first-dollar inpatient coverage plan to a comprehensive, major medical plan which treated all claims the same way. The new plan has a deductible and a co-insurance percentage that applies to all claims. We did this for numerous reasons, and obviously it wasn't all simply a cost-shift to our employees. We wanted to provide a basis upon which we could start to build incentives for the wise use of health care among our employees. And our previous incentives were totally wrong: we would not pay for an outpatient procedure, but we would pay if you had it done as an inpatient. I think Continental, along with most employers, most purchasers of health care, provided the wrong kind of incentive.

When we made the change, we were very concerned, about the negative employee-relations aspects of taking away first-dollar hospital coverage. To offset that and, we hoped, to build some long-term paybacks into our plan, we began to cover preventive health care procedures. For example, we now cover pediatric care for children, including annual physicals and immunizations, which were not covered in our old plan.

Another recent action is that we have hired a full-time medical director. Our medical director is very aggressive, and he's taken control of many of our in-house programs for health education, wellness, and health screening. He has done a lot to coordinate those activities, and while we realize that many of those are long-term paybacks, we're committed to making our employees a more healthy group.

We've also been very active in the Midwest Business Group on Health since its inception. As some of you may know, Jim Mortimer, who is the president of MBGH, is a former Continental Bank employee who went out and organized MBGH. Our activities in MBGH in recent years have been directed toward working with insurance carriers to gather utilization data. There was a total absence of utilization data on the Continental plan prior to our switch in 1981, and we've been very active with other employers in getting data collected and being able to analyze and present them in an understandable format. Another action we've taken within MBGH is to start a dialogue with four hospitals in the Chicago area, two of the teaching hospitals and two suburban hospitals. Those meetings have been going well, and we're interested in making it an ongoing dialogue, not a confrontation. We're not sure what the ultimate results of the meetings will be but we wanted to open lines of communication.

We're considering several cost-containment activities for the future. Probably the most important thing we're doing right now--and in itself it is not going to save costs--is to refine our cost-containment strategy. We are trying to answer the questions of what cost-containment means to us and what we are going to do as a corporation. And in doing that we have to answer a lot of very tough questions. How pro-active is Continental Bank going to be in the area? Are we willing to share any cost saving we receive with our employees? And how do the cost-containment activities that are currently popular relate to how we answer those questions? Once we answer the questions, we will have a better idea of where we want to go in our cost-containment efforts.

From this process we're considering more plan design changes to provide some incentives, as many positive sorts of incentives as we can, to promote health care cost effectiveness among our employees. We want to promote wise health care consumerism. An example is a list--much as the state of Illinois is doing with its plan--of procedures that can be safely done on an outpatient

basis. If our employees will do that we may waive the deductible or the co-insurance. We find these kinds of incentives attractive.

The Chicago Health Economics Council, along with MGBH, has developed a utilization review program, which they're now prepared to go out and market. We're very interested in that program and its development. Another interesting program, which John will tell you more about, is the Medical Services Advisory Program. This program would designate someone in our medical services department to consult with employees before they have elective surgery. The consultation would serve to make sure they're asking the right kinds of questions. We would offer guidance to help them make the right decisions. For example, can something be done on an outpatient basis that they're scheduled to have done as an inpatient? Are they going to check in on Friday? Have they had their tests done before they go in?

These, then, are the things Continental currently is doing in the area of health care cost containment. Thank you.

MR. FOSTER. Thank you, Harry. Our final speaker for this portion of the program is the change I mentioned from the printed program. Our next speaker is from the Zenith Radio Corporation, but it is Dr. John Kaminski, and thank you, John, for stepping in with somewhat short notice.

DR. KAMINSKI. Thank you for inviting me today; I'm very pleased to be here. We at Zenith have been working on medical care cost containment for about the past two years. At that point we were faced with some very high increases in our costs and for the first time in many years, I heard people in our organization get concerned, and say, "We really have to do something ourselves."

What we did was to establish three committees. These committees broke down into three areas. One was to study health education promotion and preventive programs. As a result of that committee's deliberations we decided to go with a communication program, and that began in January of '82. The benefit plan design committee had much more far-reaching consequences: there were a number of changes made in our programs, which did save some money for the company; but the main purpose was to encourage cost-effective use of medical care, and the correct use of the health-care system. We wanted to make sure that there were no disincentives to the correct use and the more efficient use of medical care. The third committee had a consultant come in and look at our medical department and at the way we handled our health care practices, and we came up with what we called, finally, the "Medical Services Advisory Program".

The primary objective of the Medical Services Advisory (MSA) program is to promote employee participation in health care decisions and management. And by this we mean an aggressive,

positive participation. We find, however, that in order for employees to do that, they need some help. I mean, if at any point in the decision-making process, an employee decides to challenge or question anything, that employee usually finds he or she doesn't have enough information. In this program, we are providing some assistance to the employees, so that they have a much better handle on what's going on. We assess their needs, advise on alternatives among various facilities, and advise on treatment alternatives; we will, in fact, refer employees to appropriate physicians, and we do provide hospital utilization review.

In order to set up such an MSA program, I feel, you need a medical department and you need at least a part-time medical director. You need a medical services advisor. (I'll go through the advisor's job description a little later.) You need some medical claims data. When we started in the program, two years ago, we were trying to get some information about what Zenith was doing in terms of medical costs and diagnoses and hospitalizations and so on. We got very little information on this until Blue Cross decided to institute a program that they called "Probe". As a result of these Probe data we now can tell what hospital our employees are using, what the diagnosis is that she or he is going in for, what the length of stay is, what the cost is for the basic room and board, and what the cost is for ancillary services; and we can get all this ranked for each hospital we're dealing with. We find that we have very effective information at the present time, and, in fact, so much information that that's really a lecture in itself. So I'll just pass by that and if there are some questions perhaps I can answer them later.

Our program requires reporting of hospital admissions. We ask the employee to call us prior to scheduled elective admissions, and within 72 hours after an emergency admission. We have a mandatory second surgical opinion on twenty selected procedures, with a reduction in benefits if the person does not obtain the second opinion. (The two opinions do not have to agree, but the employee does have to obtain the second opinion.) We use a medically approved outpatient procedures list, so that at the time the call is received we do know what procedures are appropriately performed at the various hospitals, free-standing clinics, etc.

At the present time MSA is not a mandatory program. But we have been looking at this since we first started with this advisory program in January. When I go over some of the data (only 40% participation) you'll see why we're thinking of making it mandatory.

The utilization review capacity, I feel, is a key to, and a very important part of, the program, and probably could stand by itself. However, I feel it should be part of the Medical Services Advisory program, because you're at a point of getting information; you're dealing with the person, and you're letting them

know, and the doctor know, what the acceptable length of stay is for certain conditions, and you can make some changes in their behavior accordingly.

The job description of the medical services advisor: I feel this person should come from a medical background. I am reminded of what the first speaker [Joel May] mentioned about the DRG coordinators; you need a similar type of person: someone who is a very good communicator, someone who is aggressive enough and innovative enough to take on this challenge. We thought at first of training our present occupational health nurses to perform this function, and found, after talking with eight of them, that they weren't particularly interested. The concept was a bit alien to them. So we decided to go to someone who was already working in utilization review, and in the Chicago area most of the people we spoke to were either former nurses or corpsmen or people with that type of background.

I think the advisor should have an education at least at the bachelor's level, and should have a couple of years of experience in a hospital, emergency room, or office practice. To start up a program, I felt that I needed someone who had at least supervisory-level experience. The people I interviewed who did not have that experience and ability did not convince me that they could start the program on their own. So we were fortunate in finding someone who had five years' experience with one of the major Chicago hospitals. The advisor should know insurance benefits, from the point of view of what they mean, how they're administered, and what they're about, and of course what the particular benefits are at Zenith. The communication skills are extremely important. Most of our program works on the telephone, because we have several locations in the Chicago area that are served by this one person. At the present time, we are dealing only with our salaried employees, of whom there are about 2500 in the Chicago area. Most of the contact is by telephone and a good telephone personality is more than essential. It's just absolutely necessary.

There must be sensitivity to medical issues. The benefits department, at first, wanted this program under its wing. I wasn't especially charging ahead trying to get the program for myself, but it really seemed that the correct place to put it was under my direction and in the medical department; and we did put it there, physically as well as functionally, so that we communicate the idea that the program should be perceived as a medical program and as a helping device.

We ask employees to get certain information from their doctors. When an employee calls the advisor we ask for the doctor's name and telephone number so that we can contact the doctor; we get the name of the hospital the employee is scheduled to go into, what the diagnosis is, and what the anticipated treatment plan might be. At this point we can certainly try to intervene and discuss whether outpatient surgery might be appro-

priate, or pre-admission testing is appropriate--in fact, whether the total work-up can be done on an outpatient basis.

In terms of the designated hospital, the program was originally conceived as a program that would switch patients from more expensive hospitals to less expensive hospitals. In Chicago, the data we have seen indicate that there is a discrepancy of apparent costs among these hospitals. After looking at the DRG presentation I can see how tough it is to come up with what costs really are. In our case, with our salaried employees, however, we find that they are using mainly suburban or northwest-side community hospitals. These hospitals, according to the data we have, are less costly than the hospitals in the city. I won't say necessarily that they're cost-effective, because we have plants in other parts of the country that seem to do the same job at a lower cost. But for Chicago, at least, they are more cost-effective.

So we go through that with the employee; we determine on what date he or she is going into the hospital, and what day. We haven't gone so far as some plans that have actually prohibited admission to the hospital on Fridays. But we do monitor that; we do advise the employee of the problems. Our employees were much more likely to cooperate with us after our benefit plan was changed, because of an eighty-twenty co-pay feature after the first two thousand dollars. Beyond the two thousand, therefore, each day that employees stay in the hospital, they're paying twenty percent of those charges. This gives them an incentive. But I believe that they would cooperate even without that incentive. We have noticed that there's a feeling among our employees that these costs have gotten out of hand, and that they're frightened by the fact that they can't afford this care, and they really would like to see something done to bring them under control.

I'll give you some specific examples of areas in which cost savings have occurred. Shifting people to outpatient alternatives, transferring facilities, and the addition of a second surgical opinion are areas where we have exerted some impact. When you get into these the way we are doing now, dealing with each person on such a personal level and discussing medical care, you get to know just what's happening.

S.S., the daughter of an employee, was scheduled to go in for the extraction of four impacted wisdom teeth. We thought it was possible to have this done as an outpatient. She was scheduled to be in the hospital for five days; I don't know whether they were going to do it in two different days, or what, but it seemed like a long time, and after discussing it the employee realized what the financial impact on him would be. We saved five hospital days, or $2500, on that case.

M.G. was a person who had back pain and was going to be admitted to the hospital for a work-up on the back pain. The

work-up was supposed to consist of x-rays and a CT scan. Our plan now pays 100% of outpatient diagnostic studies, so these were paid for in full, and we saved two days in the hospital at $650. The case of N.N. was also referred to outpatient. This was a cystoscopy. Most hospital and ambulatory care facilities and most urologists agree that the vast majority of their patients can be treated as outpatients, so there was another saving of $694.

I think the case listed for March, the diagnostic work-up, was kind of an ideal case. It was a person who was going into the hospital to be worked up for a thyroid condition. This person was scheduled to be in for five days, and the medical services advisor set up a conference call with himself, the employee, and the doctor's office. It was decided that what was needed to be done could be done while the employee was an outpatient; if there was some hospitalization needed later for surgery, or whatever, the benefits could be saved for that time.

The transferring from facilities is not a big factor. We have not shifted many people from teaching hospitals in the inner city to other hospitals. We have tried on a couple of occasions, but it seemed after investigation that these were appropriate admissions to tertiary-care hospitals. When we had an employee's child who needed to go to Children's Memorial, even though two prior surgeries had been done in a suburban hospital, the orthopaedist was doing a special leg-lengthening procedure, and apparently Children's was the only place where it could be done. The radiation therapy case was interesting. At first we wanted to have the employee consider having the surgery done at the same hospital at which the radiation therapy had taken place, because the hospital chosen for surgery seemed to be more expensive. The radiation charges were considerably higher, as you see, and because she selected the cheaper of the two, we did save $680 on that.

Regarding the additional second surgical opinion, in our administration of it for the past three months, we really haven't seen any savings in terms of surgery that was scheduled to be done and wasn't in fact done. There was one case in which the second opinion did not confirm the need for gall bladder surgery, but the employee developed more symptoms and it was performed later. Interestingly enough, she decided to go to the second surgeon to have the surgery done.

Blue Cross did a study for us on second opinions, and I brought the data along on that. These cover 88 surgeries that occurred in the past year that required the additional, second opinion. As I mentioned, we do the second opinion only on the twenty procedures that we thought might yield the most effective results. The total charge on this program was $275,000 for the 88 procedures. There were some people who did not get the second opinion, so they were penalized, and there was some money saved because of that. However, the actual saving believed to occur

from the second opinion was $47,000--nearly $48,000. The consultation charge was $6000, so it was a net saving of around forty thousand to Zenith. It appears that there are actual savings; and then, of course, there is the possibility that some surgery is actually recommended against by such a review program.

The utilization review program, in March, according to our estimate, saved $10,738. These figures of how much money we save on utilization review are, of course, our estimates. We try to be conservative in our estimate. There are considerable savings, and I think there's a definite, major impact to be made on the basis of utilization review.

We found, to our surprise, a lot of savings, in reviewing the Blue Cross paid claims reports. We now obtain a report on every claim that's being paid, and these are reviewed by our medical services advisor. These we usually receive after the fact, of course, anywhere from two weeks to a month or so later. However, we do find some things in there that are interesting. In reviewing one we found a Blue Cross error: they had listed someone on their terminal as being active when in fact this person had been terminated. This was a rather large claim of $10,000. We are able to find cases of questionable medical necessity, because we use the claims reports to find out who didn't call us in the first place. In other words, we're getting only a certain percentage of the calls in advance, so people go in the hospital and don't call us. We are able to determine who they are by these claims reports.

Here was a family that had what is so common in the Chicago area: an auto accident. The day of the accident, January 23rd, they went to a hospital emergency room in the suburban area and were released. Two days later they were all admitted to an inner-city hospital, not only the mother and father but two children. So all four members were admitted. The children stayed two days; the parents stayed three days. Someone speculated that their children had to get back to school, or something. However, after the chart was reviewed, this total case was denied as not being medically necessary, for a saving of $3461.

We are currently investigating, because of our better claims review, all auto accident cases, and have compiled a list of seventeen cases at one hospital. With this kind of pattern of admission data Blue Cross feels it can go ahead and do something about it. That is, it reviews the cases for medical necessity.

To give you the results of our first quarter, I will discuss the number of people who report to us voluntarily: twenty-four in January, twenty-one in February, and twenty-six in March. This represents about forty percent of the elective admissions. We feel that for the beginning of the program forty percent is not a bad amount of participation. We are thinking, however, of making this mandatory in some manner if our percentage doesn't

increase somewhat to a more acceptable level. The claims saving that we're calculating for the quarter is that out of paid claims of $1,221,111, we saved $53,118, or 4.3%. We feel that this is a good return. We feel that we should be able to do around five percent a month, even with this low participation. With better participation, and a little more cooperation, we feel that we should certainly be able to cut our total claims cost by ten percent with this program. The consultants and Blue Cross were a little more optimistic in their projections, but I think these are certainly things that look achievable for us.

So, to recapitulate what we've done, mainly we have structured our advisory program to promote employees' participation, help them get into their health care decisions and management, and, of course, put ourselves into the position of being involved with these decisions. If there are any questions on that, I'll be happy to try to answer them. Yes.

JOHN SCHNEIDER. One question just to reflect back on what Joel May was commenting on: When DRGs were put in place in New Jersey, one of the first things they discovered was that diagnoses and codes didn't match up very well. These are concerns that I've had with Blue Cross. I just wondered whether you've found any problems with this, when you began to look at your claims and match them up.

DR. KAMINSKI. Well, we haven't as yet, because we're not using it in that way, actually. What we're looking at are ones and twos of this and that, and I think if we tried to use them that way we'd have a lot of trouble. The one area where I think that they're probably accurate enough is, say, for a normal delivery, and the breakdowns of that kind of thing. The procedures will probably be more accurate. I think when we looked at them in terms of degenerative diseases, our next high number was cardiovascular disease. I think you're right. They [Blue Cross] are modifying their coding, apparently, so this should be helpful.

We were concerned about that when we started, and our medical services advisor was quite concerned, since he was used to a different system. We're finding, as you see, the obvious things right now, and we may not get beyond this point. We may just keep going through this same control system over and over. I might mention that the hospitals have responded favorably and they are quite interested in the program. I think some of them are considering putting in something like this for their own employees. Many of them, in the Chicago area at least, require their employees to use their own hospital. We were speaking to one hospital that has a committee that reviews admissions to other hospitals. Their plan will not pay the full amount of the benefit if they [employees] use a more expensive hospital, unless it's a justified admission.

HEALTH ADMINISTRATION, COST-CONTAINMENT, AND EQUITY: NEW PROBLEMS, NEW PRINCIPLES?

RICHARD FOSTER. Our next speaker is a philosopher; he's an associate professor of philosophy at the University of Wisconsin; he recently worked with the President's Commission on Bioethics; and in light of some of the discussion this morning about the equity of cost-shifting, and I think we had a reference this afternoon to some question that might be left to the physician--some of us are reluctant to do that, so we have an alternative viewpoint on the ethical considerations involved in cost-containment, and we're very fortunate to have Mr. Wikler with us.

DANIEL WIKLER. Many of the papers in the present collection impart knowledge that is immediately useful to hospital and health services administrators. In this new era of financial uncertainty in health services, the most welcome advice is that which tells how to hasten the cash flow through hospital units newly made into cash cows. My remarks on equity, on the other hand, are general and abstract, and they deal with constraints and difficulties rather than with opportunities. Nevertheless, this kind of other-worldliness is inherent in a subject like ethics, and must be tolerated if equity concerns are to be given an airing.

That equity must be faced head-on as a subject of discussion is apparent from almost any essay on the health system these days. The new incentives, and the new financial perils, seem to require choices and behavior that do not sit well with ethical norms that have been internalized over the years. Indeed, some commentators seem to suggest that the very success of the cost-containment measures--and the ability to forestall the need for even more drastic steps--depend in large part on the ability of health services people to modify or abandon the ethics of earlier times.

The notion that one is required to "cut one's ethics to fit today's fashions", to borrow a phrase from Lillian Hellman, is troubling in itself. Thus a subsidiary ethical question arising in the context of today's changes in the health care field is the degree to which ethical principles ought to be revised and the basis on which any changes should be made. There is something paradoxical in the notion of commanding oneself or others to change beliefs, whether these be beliefs of technical fact or ones of morals. Try as you might, you cannot come to believe that the earth is flat, or that harming innocents is morally right, simply by willing it. This is one reason why the call to adjust our ethics to permit cost-control is unappealing. Nevertheless, we may take this occasion to accomplish a worthy goal that might have the same end. We can use the opportunity provided by the sense of upheaval to review the old ethics in a critical manner, intending not necessarily to change our sense of morality to fit necessity but rather to cut a clear path through the tangle of maxims, dogmas, and taboos that often substitute

for critical reflection in ordinary morality.

At the very least, a direct examination of ethics can bring to the surface rules that are seldom enunciated but which may be very powerful in shaping health policy and institutional practices. These unstated rules serve to designate some factors in health-care decision-making as "important" and others as "irrelevant"--even in the minds of people who think of themselves as pragmatic and disdain absolutism. Certain alternatives are, in practice, ruled out by these moral norms, and others made respectable.

One administrator stated that he could not imagine insisting that a doctor on his staff tell a patient that the patient could live another six months if an expensive operation were done but that benefits had run out, or that an operation that represented a patient's only hope had been judged to be insufficiently cost-effective and that as a result the patient was being sent home. These acts were, in the mind of this administrator, simply taboo. This administrator would not be likely to formulate this taboo as a moral principle. Nor would he try to preach to the physicians or trustees about the necessity of adhering to the principle. Nevertheless, he would adopt management practices that would ensure that he would never be in the position of having to decide to disobey it, and might take steps, perhaps not consciously, to ensure that the choice did not arise. Though he might consider himself a pragmatic man, the principle would operate as an absolute, working in the background to shape policy and to direct management. It is thus crucial, in a time of testing and of change, to become conscious of what these taboos and absolutes and principles are; to identify the ones we are, in actual practice, operating under; and to see whether or not we really want to continue our allegiance to them.

Allocation Decisions

In much of the literature of medical ethics, a distinction is made between two kinds of equity issues in health services. These have been labelled "micro" and "macro", though these terms do not correspond to the economists' use of them, which is better known. Micro-allocation decisions are questions for individuals and, occasionally, institutions, such as "Who gets this kidney?". A transplant surgeon may have but one kidney ready for transplantation and six patients who need it. The physician, in deciding who will live, may have to "play God"; but it is his or her decision to make. Macro-allocation decisions, in the field of ethics, are social in nature: Should we, as a society, fund kidney-transplant programs? Should we train people to transplant kidneys and coordinate donors and recipients?

These two kinds of allocation decisions are distinguished one from the other in a number of ways, but perhaps the most crucial is that which I have mentioned, i.e., the agent of allocation. In micro-decisions the individual doctor or admini-

strator is choosing; in the macro-case it is a question for legislation or other social decision-making process, or for an aggregate of individual decisions, as in a market.

Both micro- and macro-allocation decisions can be terribly painful to make. There is a natural and understandable tendency to try to avoid choice altogether. On the micro-level, the least active policy is a lottery or a first-come, first-served policy. In the transplant surgeon's case, this would mean making no attempt to decide whether or not one patient is urgently needed by his or her family, or will make an important contribution to society, or has already made a contribution for which he or she should be rewarded. Instead, we make a random selection among those who are medically eligible. (Of course, this too is an allocation decision, but in the case of a coin flip the surgeon is able to point to the coin as the chooser and thus avoid the stress of making tragic choices.) On the macro-level, the attempt to avoid decisions takes a different form. One recourse here is to try to provide everything to everybody, denying the fact of scarcity. If there is scarcity that must be faced up to, an appeal is made to take money from other spheres of activity--the favorite, of course, is the Defense Department--in order to rescue any medical enterprise threatening to sink into financial oblivion.

Inflation in health costs, together with reductions in budgets, has now blocked this favored solution to the problem of having to make macro-allocation decisions. Equity simply cannot be ensured by providing absolutely everything that might be of medical benefit to everybody who might need it, maintaining all the while the levels of reimbursement and of control over conditions of work to which health-care providers and institutions have become accustomed. That solution is no longer open. Choices have to be made.

But the necessity for conscious choice exists not only, or even primarily, on the macro-level. Analogous to the practice of cost-shifting, wherein payers who ought not to have to pay certain charges are made to do so, there has arisen a practice of "responsibility-shifting". Responsibility-shifting causes macro-allocation decisions to be pushed down onto the local level rather than being made on a national or societal level. This administration, as did, to a degree, the previous one, is adopting a budgetary approach to the crisis in health costs. Instead of setting health-care priorities by democratic decision, or by careful evaluation of the nation's health needs, this approach forces the local institution and the individual physician to make decisions about allocation within the constraints of a budget put in place by bureaucrats in distant capitals.

Thus the two sorts of equity issues merge. What was seen as a macro-allocation decision, a question of equity in the large area of access to health services, is now made, through responsibility-shifting, into a micro-allocation decision. If

this is so, then the same kind of process that prevents the evasion of real choice with respect to the macro-allocation questions of equity now affects the micro-decision. The individual institution and provider have to abandon the hope of a lottery or other choice-avoidance maneuver, and must make substantive, and preferably principled, allocation decisions.

Some Significant Equity Issues Arising in Cost-Containment

A list of equity issues arising in the context of cost-containment in health care cannot be drawn up without settling on definitions for both "cost-containment" and "equity". Under the rubric of "cost-containment" we find not only a host of distinct strategies but also a number of different goals. One meaning of cost-containment has been a reduction in the rate of increase of unit costs for a given product or service. A second is containment in aggregate costs of all health services: the amount spent on health care in the U.S.A. in a given year. Alternatively, "cost-containment" is the term used to describe an effort to reduce the use of non-beneficial services; or services that are not cost-effective; or services that are not very effective, apart from cost. Another favored meaning for "cost-containment" is simply a slowing of the rate of increase of government health budgets, regardless of whether this budgetary move causes costs to be shifted onto others, or even increased. And there are analogous meanings in other domains: a reduction in the amount that an employer spends on the health care of workers or the amount that an insurer spends in reimbursing providers for health care of insureds.

The equity issues vary to a considerable degree depending on the goal of a cost-containment effort. Only if cost-containment is brought about through some kind of management magic, with services provided exactly as before to the same people, but at lower rates, is there no real equity concern. And even here I suspect that equity questions would simply be shunted off into some other domain, such as dealings with employees in wage settlements.

If management magic, which is a difficult feat at best, fails to accomplish all of these ends, then someone must lose out. Either someone pays more, or someone gets less, and the equity issue is joined. These equity questions are not mysterious. But though they are referred to regularly, they are not much talked about. There is a strongly felt imperative to contain costs, and too much attention to the equity problems would undoubtedly interfere with this effort.

1. The most obvious problem of equity on the horizon in health services is under-treatment. The principal method of cost-containment, after reductions in eligibility, has been the reversal of incentives to providers. This strategy assumes that providers respond to incentives. If the incentives encourage providers to stint on care, there must be all kinds of provisos,

controls, and warning signals to guarantee adequate care. The federal government has assured us that the DRG system will include these. It is uncertain whether these will work, and it is unclear whether there will be comparable controls in cost-containment measures imposed by other payers.

2. The tightening of eligibility requirements is also a rationing device, though it may be presented as a crackdown on cheaters or in some other savory guise. If those whose entitlements are taken away cannot find health care under some alternative program, or if the providers to which they turn cannot afford additional bad debts, severe problems of access will appear. When providers were under less intense financial pressure, the eligibility-tightening might not have had a devastating impact; but now there are few agents in the health-care system with any resources to spare.

3. Competition for contracts under preferred provider organization (PPO) arrangements, which requires every possible means of cost-control in order to present the lowest bid, could make it impossible for providers to continue their cost-shifting strategies for dealing with bad debts and under-reimbursement by government. This bind could force providers to cut teaching programs, or research, or provision of services to the indigent.

4. If the cost-shifting is permitted to continue, and if it is concentrated on fewer and fewer parties, there will be even more of a backlash from those who pay their bills, particularly their employers. Thus far, this has taken the form of business health coalitions, which attempt to resist the cost-shifting prompted by the governmental strategies. But another response may be severe cutbacks in employee health benefits. In its most extreme form this may mean total termination of work-based group health coverage, which is said to have occurred already in California. Thus large numbers of employed workers could join the unemployed, the near-poor, and the "non-deserving" poor in the ranks of the uninsured.

5. The specter of a two-tiered health system is already being supplanted by that of a multi-tiered one. Those with adequate health insurance will get the best care, though high deductibles will force some people to pick and choose carefully. Those covered by Medicaid and certain other programs will be increasingly confined to a separate and dubiously equal system. A third, and lowest tier, increasingly concentrated in a shrinking number of public hospitals, will be the fate of charity patients not covered by any program.

6. The advent of substantial deductibles and co-payments in cost-containment efforts raises other equity issues. Costs will be contained if the fees work, which is to say that utilization of health services will be reduced. Yet this is the ultimate form of responsibility-shifting, for the individual patient or consumer must now be his or her own rationer. If that person is

in a position to make wise choices in the health marketplace, this will have its advantages, but patients are rarely in that position. If, as seems to have happened in practice, patients who are forced to ration choose to skip needed preventive services, health will suffer (Dallek and Parks, 1981). This may exacerbate already existing equity problems: hypertension treatment, for example, may "feel" much less necessary than treatment for acute but transient conditions. And hypertension disproportionately affects those who suffer from poverty and racial discrimination.

7. These same deductibles, co-payments, and limits to coverage place a financial burden on families. The disincentives work to reduce utilization in precisely those families who feel the burden most; they may have little or no disposable income to spare. Families who can bear the extra charges can also afford, relatively speaking, to ignore the disincentives and keep utilization levels high. In this sense, the burden of cost-containment is placed squarely on the least advantaged, and the disparity in ease of access to care between people of different income levels is increased.

8. The financial bind imposed by the cost-control disincentives will increase the pressure on some families to choose between health needs and other kinds of needs, extending the equity concerns beyond the realm of health and health care. Conscious decisions might have to be made to satisfy the needs of some family members over others: between a new hip for Grandma and a tutor to keep Junior in high school.

9. Finally, there is a distinct possibility that treatment decisions involving the most basic life-and-death concerns will be increasingly made with budgetary factors in mind. Decisions to terminate care, including orders not to resuscitate, may be more frequently encountered in public hospitals, and for non-insured patients in other hospitals. Aggressive care may become the right of the wealthy and the well-insured, while "natural death" and the hospice become the best hope for the others.

Not all of these issues will arise, particularly not in the stark form in which I have presented them. Yet none is inconceivable and some are presently with us. These are in fact but a few of the equity issues that loom on the horizon as the reluctance of employers and governments to tolerate medical inflation is expressed in attempts to reduce utilization of health services. To label these concerns equity issues is not, I stress, to prejudge them. Not all of these difficult choices should be avoided; it is not always wrong to make people think through these decisions. The problem of inflation is not an illusion and must be addressed.

Still, none of these prospects is attractive. Each seems to violate something in our sense of justice or fairness, to require burdens or choices that citizens of this wealthy country ought

not have to face. The scarcity of funds made available for health care, then, produces a scarcity of palatable options in health policy. It is this second condition of scarcity that ought to lead us to reflect long and hard over what we mean by "equity", and what it is that equity demands of each party. Denying the problem is just as unhelpful as shifting responsibility and blindly cutting budgets; none of these sets out a coherent set of principles for conduct during this era of difficult choices.

Formulation of an acceptable set of principles of equity is in some sense a philosophical enterprise but it cannot be left only to philosophers. The principles must be capable of guiding policy, and their development must be abetted by the essentially practical people who run the health system. Failure to come up with usable standards of equity will leave the important ethical issues to be decided in a more-or-less random way through the pulling and tugging of interested parties attempting to hold their own as resources become scarce. Conscious adherence to such a set of principles could, on the other hand, serve as a minimum standard of performance for the health system vis-a-vis the least advantaged and the most needy. This would help to assure us at least that we were not condoning any new (or old) inequities, regardless of how the system functioned in other respects.

The President's Commission's Principles of Equity

I would like to be able to offer a set of comprehensive, consistent, and usable principles by which the equity of the health system could be judged. Though I and any number of others are devoting energy to this sort of project, the difficulties are great--and here I am speaking of uncertainties on the theoretical level, to say nothing of the lack of an adequate data base. Nevertheless, it will be useful to present a standard of equity that can be seriously considered as a candidate, both for its own merits and as an example of this sort of intellectual project. In a friendly but not necessarily uncritical spirit, then, I present, in brief summary, some conclusions of the President's Commission for the Study of Ethical Problems in Medicine. This body was created in 1979 by an act of Congress to report to the nation on a variety of topics, ranging from the definition of death to issues in genetic screening. What some observers considered to be its major assignment, however, was a charge to consider the adequacy of existing patterns of access to health care, particularly as regard income and proximity to urban areas.

There have been a number of commissions in the past that have been asked to study the problem of access to health care, but this one was nearly unique in being chartered as a commission on ethics. Its job, that is to say, was not confined to fact-finding, but extended also to moral argument. This element of its mission shows itself in every one of the Commission's many reports; and its willingness to take morality seriously enough

for analysis and argument--to rise, that is, above slogans and gut-level judgments--is not typical of governmental bodies.

In the case of access to health care, the Commission funded a great deal of writing by health services researchers, involving some new research but largely aimed at summarizing, in a form useable by policymakers, two decades of fruitful investigations by scholars in the field (President's Commission, 1983). The Commission's data showed significant gaps in insurance coverage, demonstrating that the access problem had never been fully resolved. Beyond these empirical findings, however, the Commission undertook to re-analyze the concept of equity in access to health care. Though it found no unanimity of opinion about the meaning of equity in access to health care, even among health services researchers, it did find one standard that held center stage: that equity is distribution according to medical need. According to this standard, a health system is equitable just in case utilization of health services is a function of illness, vulnerability to illness, and other health needs, and not a function of age, race, place of residence, income, or other circumstance apart from health status.

While the Commission did not entirely abandon this standard, neither did it fully endorse it. I will present the standard that it adopted instead, but it will first be useful to present some of the implications the Commission saw in it for cost-containment. Cost-containment was not on the Commission's original agenda. But by the time its report on access to care was in final preparation, the access problem had been replaced in the political limelight by the cost issue, and the Commission felt obliged at least to nod in its direction. The Commission reported three judgments on the present administration's cost-control proposals.

First, the Commission opposed the Medicaid cutbacks without reservation. In the Commission's view, the eligibility rules were already too restrictive. In the popular imagination Medicaid covers everyone below the poverty line, but in fact only half of these people are eligible. Nor are the uninsured half necessarily covered under other programs. Thus, in the Commission's view, there simply was no excess that could be cut away from this program. Similarly, co-payments were condemned on the grounds alluded to above, i.e., that they have led to omission by the poorest recipients of such necessary services as prenatal care and immunization, and, in any case, represent a financial burden that is being placed precisely on those least able to tolerate it.

A negative finding was reported also on the pattern of overzealous review of Social Security judgments. Two-thirds of these have been overturned upon appeal, and, in the Commission's view, rightly so. The disabled have great difficulty obtaining health insurance in the marketplace because their disability constitutes a pre-existing condition, and the same disability

excludes them from workplaces in which group coverage is provided. However, the Commission was quite ready to accept the administration's proposal to tax employer contributions to employees' health insurance. And it endorsed this measure even though it might lead to the employees obtaining less comprehensive insurance than previously, to being financially burdened, and to obtaining less health care.

This third judgment is, in my opinion, a key to understanding the Commission's approach. The pattern of positive and negative evaluations made by the Commission of cost-containment strategies makes sense only if it is understood as following from its analysis of the concept of equity in access to health services.

The Commission did not, I repeat, endorse the formula of "equity = use according to medical need." Though this formula has the advantage of simplicity and intuitive appeal, and though it is accepted by many in this field as axiomatic, it carries a number of disadvantages. For example, it makes equity impossibly expensive, given the lack of boundaries on the concept of medical need. This in turn leads to equity being seen as an unrealizable ideal, and therefore one not to be taken too seriously as a requirement of health policy. Further, not all medical needs are equally serious, and some are much less serious than certain needs urelated to health. Thus, even if we are committed to securing individuals' welfare, it will not always be rational to spend dollars, especially public dollars, on satisfying health care needs. It hardly makes sense to give irrational policy the status of an entitlement.

For these and other reasons, the Commission adopted an alternative conception of equity in access to health services. The Commission's standard required the provision of universal access to a "decent minimum" of health care services, that is, to a basic package of health care benefits.

It is notoriously difficult to provide some specification of what constitutes a decent minimum in health care without being arbitrary or overly inclusive. It is obvious that face-lifts would not be included, but that is all that is obvious. Nor did the Commission provide much help in this regard. Thus, the Commission might be seriously faulted for relying on an elusive concept in the very foundation of its health-care policy prescriptions.

Nevertheless, I believe that this kind of criticism would be misdirected. The important issue, in this context, is not the precise menu of benefits that must be provided in a basic plan, but rather the acceptance of a concept of equity according to which allocation of health resources above the minimum are not, in general, issues of equity. A health system that provides universal access to the basics will be fully just under this proposal, whatever the distribution of non-basic services or of

their costs and availability. Failure to provide care above the basic level would in general be considered discretionary in terms of equity--except derivatively--insofar as unjust differences in wealth generally allow favored individuals to purchase these (and other) desirable services.

The reasons for the Commission's approach to cost-containment, then, are clear. Medicaid eligibility restrictions and overzealous review of Social Security disability status threaten access to the most basic services on the part of those who may have nowhere else to turn. These were thus deemed inequitable. Taxing employers' contributions to health insurance, however, even when this leads to reductions in utilization of health services, does not threaten access to the minimum. These employees are generally covered by insurance at a level well above the minimum and cutbacks in coverage above this level are not to be regarded as involving questions of equity (though they may be undesirable for other reasons, including some moral ones).

The adoption by the Commission of the "decent minimum" standard of equity in access to health services was not an arbitrary choice, nor, I believe, was it an overly pragmatic or opportunistic one. It may be admitted that in an era of ample resources and price stability there would not have been the motivation to move from the more demanding standard of equity that had been commonly accepted. Given the needs of the moment, however, the Commission could, and did, defend its philosophical position with moral argument.

The Commission's equity standard was intended to follow from its analysis of the notion that health care has a distinctive moral importance. This notion is incorporated into much, if not most, of the literature on health services. It is opposed to the view that health care should be bought and sold in the marketplace like beer and radios. Nor does it coincide with the well-known thesis that health care is unsuited to the market only for technical reasons concerned with consumer information.

The Commission affirmed, instead, that health care is the sort of service that ought to be a matter of universal entitlement, guaranteed, at least in the last resort, by the federal government. The reason for according it this distinctive status is the important role that health care can play in maintaining the essentials of a decent life. It helps to provide freedom from early pain, disability, and early death. It yields information that is essential in making both short-term and long-term plans. And it is a necessary condition of equal opportunity, which is in turn a fundamental condition of a just society.

These simple claims do not themselves suffice to show that health care is distinctively important. A convincing demonstration requires a far more complex and detailed argument than this. But a gesture in this direction can be found in the Commission's

report and attempts are made in more detail in its appendices, written by a variety of independent scholars at the Commission's request.

In any case, the rationale behind the Commission's equity standard, and hence its judgments on cost-control methods, is understandable even from this sketch. If health care has instrumental value for the reasons the Commission gave, then not all health care would be required by considerations of equity. The society would need to ensure only that enough health care had been provided to meet the need for equal opportunity and the other ends in question. And if these were in fact provided, the other health services might be left to the market or distributed on some basis other than entitlement.

Do We Really Need to Talk about Ethics in Relation to Cost-Control?

The Commission's analysis of the notion of equity in access to health care is not the last word on that subject, nor were its judgments on particular cost-control measures. The Commission did not pretend to omniscience, and its many reports are now being incorporated into on-going debates only after the application of critical scrutiny from scholars and others. Nevertheless, I put the President's Commission report on access to health care forward as a model. Though one may disagree with it in whole or in part, it had the virtue of basing its policy judgments on a comprehensive view of what equity was all about in the health care system. Its recommendations on cost-control policy did not represent a series of gut-level feelings, nor did the Commission invoke a new "sacred principle" to rationalize each judgment. It gave every sign of having thought first and concluded second.

Today we stand in special need of this kind of thoughtfulness. Because the health system is undergoing fundamental change in its organization and in the roles occupied by many professions and institutions, we must accept the fact that the verities of the past, including the moral ones, will have to undergo some revision. But nothing has prepared us for what seems to be a stampede away from principles and goals that only yesterday were held to be sacred. For example, the hallowed "right to choose your own doctor", which for many years figured in one of the chief arguments against federal financing of health care, is not always compatible with preferred provider arrangements. For this reason, we might expect as much opposition to PPOs as there used to be to Medicare. But, of course, this is not the case; we are encouraged instead to accept the change "philosophically".

We were assured that the physician is the best judge of what is best for the patient; the nearly total professional autonomy accorded the physician was balanced by his or her professional responsibility to make sound treatment decisions on behalf of the

patient. But today we are told that it is the patient who must have responsibility for making these treatment decisions, as the medical marketplace, co-payments, and deductibles rely on the consumer's judgment of what is medically necessary to contain costs by eliminating "over-treatment".

Most fundamental, our understanding of the moral position of the physician is being turned upside down, again with hardly a pause for explanation. In previous years it was axiomatic that medicine was a profession, meaning in large part that physician behavior was determined by the profession's sense of what was right and proper. But the picture of the physician that underlies the competition strategy and the new cost-control strategies is markedly different. The physician is viewed as a classic example of *Homo economicus*, responding predictably to incentives, the most powerful of which are monetary. What is not noticed, or at least not pointed out, when we change our picture of the physician in this way is that such a change requires the jettisoning of much more. The trust we place in physicians to make decisions on our behalf when we are incapacitated, for example, makes little sense if physicians are merely economic maximizers. Of course, the competition strategy need not assume 100% response to these incentives, and it can build in some safeguards; but the fundamental tension remains.

Finally, the actions on the part of many parties that have the effect of dumping the poorest patients into overloaded public hospitals seem to presage a new attitude toward the precept of one-class health care. Never mind that we never fully achieved this goal. The point is that, after years of moving in that direction, we seem to be moving away from it by design. The policy of first-class care for all is abandoned for that of the low-hung safety net, which in turn is transformed into sink-or-swim. Once more, the old principles have been abandoned without debate, due process, or adequate notice. Instead of there being a search for a rationale for the new practices, these subjects are simply avoided.

As with the equity issues listed earlier, I do not mean to suggest a negative view of all of these changes of principle. Indeed, certain of them are, in my opinion, for the better. Several of the old principles and standards were mostly propaganda anyway, and are better replaced by ethics that accord more closely to actual practice. What cannot be welcomed, however, is the resort to what might be called "philosophical opportunism": the shedding of last year's values as if ethics were a matter of taste or style. New slogans are easy to manufacture, and they may serve to rationalize any number of policy choices that would previously have been considered unconscionable. Their acceptance, however, in no way demonstrates their ethical validity. To be sure, new circumstances require us to rethink priorities and, often, to change policies and goals. If we are about to break the Medicare bank, we cannot continue as before. And it is undoubtedy true, as some have insisted, that reforms were needed

even before the crisis in costs.

Change may be necessary, but there is no guarantee that changes in themselves can be reconciled with ethical standards worth taking seriously. This is especially true of those changes in the health care system that result from the sometimes-desperate attempts of threatened institutions and practitioners, to whom responsibility has been shifted by a government unwilling to make its own choices and defend the morality of these choices in public view. The shifting of responsibility for deciding on priorities and entitlements in health care, of which we spoke above, may be improper, but it is a fact. These individuals and institutions are therefore more than ever in need of a defensible ethical code. Though they may sense little room for maneuver, given the need to survive, and though they may resent being cast in the role of moral agent, the fairness of the system has come to rest largely upon their decisions. It is therefore necessary to address issues of equity and ethics forthrightly; to think through the older taboos and imperatives and the changes that may have to be made in them. And institutions and individual providers in the health care system must accept constraints imposed by principles of fairness, even when they feel, with some justice, that they themselves are not being treated fairly by the system as a whole.

Bibliography

Dallek, Geraldine, and Parks, Michael. "Cost-sharing Revised: Limiting Medical Care to the Poor". Clearinghouse Review, 1149 (March 1981).

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Securing Access to Health Care, 3 vols. Washington, D.C.: U. S. Government Printing Office, 1983.

COALITIONS AND COST-CONTAINMENT

RICHARD FOSTER. We can count ourselves extremely fortunate to have such a distinguished pinch-hitter at the last minute as we have for our next speaker. Willis Goldbeck is head of the Washington Business Group on Health, has a distinguished record there, and has really been one of the pioneers in the business coalition movement, having been very active even before Harvey Sapolsky came on the scene. We're delighted that you could be with us, Mr. Goldbeck.

WILLIS GOLDBECK. I'm glad to be able to stand in for somebody whom I'm terribly fond of and I know wishes very much that he was here, Larry Lewin. He is really suffering from the ultimate problem of a policy analyst and critic of the health system: he got sick. And that means that he is being dealt with by the medical care delivery system, and the jury is still out as to what that will deliver for him, but we hope that his back gets better in a hurry and we know that he was very sorry not to be here with you.

I'm going to try to pick up on a number of things that came out of this most interesting talk, that you [Daniel Wikler] just delivered, sir. I had rather loosely entitled my discussion "A Society in Search for Balance", and I think that's consistent with the theme that you were articulating. The coalition movement--and it probably is at about that level of activity at this point--comes out of a context of an evolving role for the purchaser of health care in the United States, and really has value only if looked at within that context. It is not an end in itself; it is merely an institutional vehicle for accomplishing certain other ends, and thus I think has often been overdescribed--even though its life is very young in America--as a potential solution when in fact it's just a vehicle. There'll be more on that theme as I wander around in the next few minutes.

The basis of these cost-management--and we use the word "cost-management" rather than "cost-containment"--endeavors on the part of the purchaser is not anti-medicine or anti-hospital or anti-physician, but rather anti-waste. And it's predicated on a very firm belief: that this nation will have absolutely no choice but to ration care in the most onerous and organized fashion very soon, if we don't grapple almost ferociously with the question of waste and restructuring some of the system; and that such rationing will redound to the benefit of nobody in the system. Therefore making the change is not inherently an attack on anybody currently in the system. And I think it's very safe to say at the outset that all of the factors that got us to where we are could more than enough bring blame on every actor in the system: the purchasers, the doctors, the hospitals, the insurance guys; you name it, we can find a piece of blame to throw on everybody and can probably pass by that aspect of this whole thing very quickly.

It also leads you to a rather simple conclusion: that there are damn few surprises in the system. The economic incentives in the medical care delivery system led to the behavior we have today in an eminently reasonable, though not necessarily desirable, fashion. It is equally understandable that whoever decided that that wallpaper goes with this rug has a problem. But the outcome is very clear: if you put the two together you get whatever you have now, which at the end of the day should be a headache. And that's where we are in the health care delivery system. Same thing. But neither of those folks was necessarily at fault.

So, is this theme all a bunch of nonsense? I mean, a few guys running around starting little groups in little towns? Or is there something serious behind this? Well, I suggest to you that there is. Two examples will illustrate: Deere, Incorporated--a quintessential American firm producing tractors in the midwest--had health care costs in 1977 of sixty-four million dollars. They did a ten-year analysis of what their costs would be in 1987, assuming the same benefit level and no new employees. The projected cost of health insurance premiums in 1987 was over two billion dollars. Even a five-billion-dollar-a-year corporation, rather obviously, can't be paying two billion dollars a year in premiums. So a company, having done that sort of analysis, has absolutely no choice; it is very easy for it to make those kinds of decisions, that it must act. It then, it is hoped, begins to act in an ethical fashion, or at least to be concerned about ethics and other sorts of values in the society. But the decision to act is no longer in question.

Another company of a similar nature, Caterpillar, just took a seven-month strike over a non-health issue that happened to equate in pennies to about a thirty-cent-an-hour labor issue. They took a seven-month strike. Health care costs for Caterpillar right now are up to 21 cents an hour. Any doubt they'll be prepared to act in the future? Absolutely not.

That is what is underlying the movement, to a very large degree: the understanding that there is waste; there are targets of opportunity, and an absolutely compelling set of numbers on which actions must be taken. Perhaps equally significant is the fact that all the trends that led to that set of numbers, and to this growing concern on the part of purchasers--all those trends, particularly the ones that are exogenous to the health care system--are worse in 1983 than they were in 1981, which led to the 1982 numbers I just talked about. So the outside forces instigating this kind of a movement are growing, not shrinking.

And some of those are good forces, from another standpoint. It is really upsetting, particularly if you're an ethicist, to hear the aging of the population always spoken of as though it was an abject failure of the society. It's one of our greatest successes! And anybody over fifty will absolutely agree with that. But there's no question that it is an economic problem;

it's also a tremendous opportunity. And there is no biological imperative that says that we all start to rot on cue at sixty-five. That is only because of the way we have built our behavior system, the way we purchase health care, and other factors in the society. We do not have to do that. There's nothing in terms of our cellular make-up that says that we fall apart on cue at sixty-five; we don't need to have the over-65s using four times the care of the under-65s. We choose to do that--often in ignorance, but it's still a choice that is at our footsteps, if you will.

You [Daniel Wikler] spoke a moment ago of the values and the shifting of values, perhaps even the throwing away of some old values. And you questioned whether or not that was good. Very fair question. Let me suggest that some of those values were myths to begin with. And one of the things that the coalition movement is doing is providing a vehicle, an educational base, a forum, in some instances, for the purchaser to understand and begin to cope with the breaking down of myths. Let me just cite six, very quickly. One is that the doctor is always right, knows the most about "our bodies, ourselves". The second is that the hospital is inherently good, or even stays good over time. It's a very important concept for a person in the business community to come to grips with. The hospital that that individual or that company may have helped build thirty years ago, and served diligently on their board, for the sole reason of community good, may today be the hospital that that same individual, and certainly that same company, should lead the way to closing. And what is important is that it's for the same objective: the community health good.

Third, that there ever was such a thing as an insurance carrier's dollar. No insurance carriers spend their dollars. They don't have any dollars, so they have nothing to spend. They spend your dollars, my dollars, everybody else's dollars; they have no dollars. They ought not to have any policies or anything to say about anything--other than technically, in which case they could be very fine experts. But we should not lose sight of the fact--and it shouldn't be an insult to them, and it isn't intended to be an insult--that those are not their dollars they're spending. And how we ever succumbed to the idea that it was their money to spend after we had blithely handed it to them is almost beyond comprehension today, and in fact it is so far beyond comprehension today that there is no more growth of group insurance in the United States, of big group policies. It's all going to self-funding and administrative services contracts. It's out of the indemnity insurance game as far as any big companies are concerned. It's certainly the trend; it's also even already the majority.

Number four (or wherever I am on the list) is that benefits are something to be given away, and, therefore, it's inappropriate for the company to intervene. And that's an internal-to-industry philosophical shift of great importance, because until

rather recently, it was considered inappropriate to manage a benefit. "Benefit" was something that either was negotiated or was picked to be given away as part of compensation. You don't tell people what to do with their thousand dollars that you give them in their pay envelope, and you don't tell them what to do with the other aspects of that pay envelope that may come in other forms: life insurance, health insurance, whatever the heck else it might be; vacation time and all of that. It is only in the last couple of years that you're beginning to see some critical mass of companies deciding that benefits, in particular, now, health benefits, are a corporate and employee asset that deserve to be managed, and that that's not in some way violating the relationship with the employees. The management function can enhance the value of the benefit; it need not constitute any kind of a take-away.

The fifth is that the norm is in some way good, or even barely acceptable--"norm" in terms of prices, "norm" in terms of standards of medical care, "norm" in terms of average length of stay, beds per thousand; you name it. All the norms are terrible, and have no basis of support whatever, because they were not designed from any basis. They have evolved. Perfectly understandable; nobody was pernicious about this. But to decide, because you do some mathematics and it says, "There are a lot of places that today have four beds per thousand. There are some that have less and they aren't all dead. Therefore let's make four the average; we'll say that's okay and we'll try to get everybody down to four," is not a very scientific basis for deriving the norm, any more than length of stay. You take the lengths of stay for a given DRG, you come up with the median, you say that's what it ought to be. I haven't the faintest idea whether that's what it ought to be. It probably is the point at which you at least should start questioning whether "below" means underutilization or "above" means unnecessary utilization. But there's nothing finite about those norms; and let's face it: how did the norms get to be norms? They incorporated all the outlandish behavior in the system to create the norm. So it can't be right.

And last, that somehow or other, if you do anything about cost containment or cost management, it equates to a reduction in quality of care. And all you have to do is be in our kind of role, where we run around the country trying to get purchasers to behave differently, or deal with Congress trying to get Congress to behave differently, in ways that may reduce somebody's share on the provider's side of the economic pie, and the instantaneous response is "the bodies will be in the street. People will be immediately cut out of the system; we can't possibly function with a penny less." Absolute nonsense! In fact, in many cases, an otherwise managed, differently designed, and less expensive benefit can produce infinitely improved health outcomes, by getting people the right care, in the right setting, from the right level of provider, in a managed system. So all the coalition in many instances is, is a vehicle for grappling with the difficult

ethical, economic, benefit, industrial-relations, and demand-supply-side relationships around that set of values or myths or whatever you want to call them.

This searching for balance that I spoke of is causing these coalitions and their individual corporate members to come to grips with the fact that we're never going to have regulation or competition; that it's going to be a balancing act; that we do not have anywhere near balance between medicine and health. In the last four decades, over 94% of all dollars expended in the United States on so-called health have been spent on medical care and medical research. I don't care what game you play; ninety-four to six is a lousy final balance, particularly now, knowing what we know about life-style, and the environment, and other factors, in terms of their relative impact on health outcomes, the health status of the nation. So to say that we need a greater balance is not to attack medicine, but simply to say we clearly need a shifting, a re-ordering, to the degree that you get some balance in the system.

And you [Mr. Wikler] mentioned free choice, which I was delighted to see you mention, because I think that is one of the ultimate myths. We've never had free choice except in a legal sense. One of the finest PR jobs any organization ever conjured up was that the American individual consumer wandered through the maze of medicine shopping for the best deal. Nonsense! Companies didn't. My God, aggregate purchases that wrote checks for fifty million dollars didn't shop, and had no information on which to make a selection. Did you and I? Did our parents? Was the family doctor the result of a consumer program? Give me a break; it never happens. And in fact, classically, the doctors don't know themselves the other good guys or bad guys in town, let alone publicizing it. Where is the list of comparative information by hospital, by procedure, by price, by quality outcomes? How many doctors tell a patient, "Here are the five hospitals that will do the procedure, here's relative morbidity and mortality statistics; take your choice." Skip the economics; hold everything equal in dollars and cents. Do we have freedom of choice? Of course we do--legally. But freedom of choice is meaningless without information. And one of the things that the coalitions and the whole purchaser movement are involved in is breaking the barrier to the access to information, to get price- and quality-specific, provider-specific information so that people in fact will be able to exercise meaningful choice, not just "free" choice.

All of these kinds of thing are taking place within the context of a rapidly evolving societal structure, which is quite out of synch with much of the corporate benefit structure, historically--and, I might add, also the public policy service delivery structure, historically. Much of our public and private policy is still predicated on the concept that a family has a man at work, a woman at home with children. That is less than one-tenth of the family households in the United States today. I

don't care whether one morally likes it or dislikes it; that happens to be who's home: nobody! And that changes who's at work, which is everybody: the mother in another building; the kids in a day-care center (increasingly company-sponsored). The average twenty-year-old will move nine times in a working life in the United States, with what facet of family coming along for the ride, or going in what different directions? The implications are staggering in terms of benefit design.

The nature of work in America is changing; and underlying this is a tremendously important factor, noted by a number of futurists, that the fact of the matter is that this is the first time in history anywhere on this globe that a nation can achieve full productivity without full employment. We don't need, from a productivity standpoint, to have everybody at work. It is not any longer, for the nation, a survival issue. For an individual it may very well be; and certainly psychologically, with all of its physiological ramifications, work is very much a precursor to good health. But if work is not necessary for economic survival, it makes it far more difficult to match the bodies with the tasks, or at least enough of the tasks. It is within this context that issues such as access are re-emerging. And you're absolutely right; we now have a new constituency marching on Congress, under the rubric of "health insurance for the unemployed". In 1975 it would have been the rubric of "I want care, help, national health insurance". But it's a different constituency. And its political implications should not be misunderstood. This is the same group that only three years ago on the average was middle-income, employed, educated, home-owning, two-car-owning, anti-welfare to the nth degree, anti-government; and is now coming to Washington saying "Take care of my health insurance--et cetera." The access issues have new constituents today.

So out of all of this searching for balance and breaking down of myths and new societal structures, we have some new societal configurations and institutional mechanisms, one of which is the coalition. It is nothing more than that. And that coalition is coming about with purchasers increasingly understanding that despite what doesn't sound like a whole lot of joyous messages in the foregoing comments, we do have choices, and they have choices. We have a lot of choices. We have choices between, as Walt McClure would say, the high style and the low style practice of medicine.

We have choices between the Portlands and the Baltimores. If you were an employer and you were going to open a new plant, and you now cared about health care costs the way you used to care about housing costs, educational opportunity and quality, and other societal factors that have had implications on where people located their plants, you would now look at health care. You'd look, for instance, at Baltimore, which is a thriving, exciting town today, one of the towns in the United States--center cities in the United States--truly on the way up, but

you'd look at that and you'd say, "average bypass patient (DRG 107 in today's language) would spend slightly in excess of twenty days in a Baltimore hospital for bypass surgery. If I went to Portland and set up my plant, it'd be 9.4 days. Same outcomes, super city, just as good medical care."

If that holds true--and it does--throughout almost all 467 of those little DRGs, where do you put your plant? You don't join the revitalization of downtown Baltimore, because those are serious numbers. And those numbers are not only economic numbers; they are "quality" numbers, and they are "appropriateness" numbers. And it is increasingly important for the corporation and the coalition that are trying to change this economic system's delivery mechanism to get serious about the impact of location and appropriateness on the care received by the employees, because that is one way to make them an ally with the company in terms of changing the negotiation structure, the demand on the supply side.

Twelve extra days in the hospital equals x% greater opportunity for infection, for medically compensable events, right on down the line. It's not a fluke. We also have over 30,000 people a year who die in the United States from hospital-based infections, getting closer to the auto-accident level every year; 40,000 hurt in New York per year in hospitals. Studies in California by the California Hospital Association: better than twenty percent of all the people who walk in the door of the hospital end up with some medically compensable event. And not only that, it's a lousy hotel. Why spend twelve extra days there for no medical reason? Overpriced hotel, to boot. So they're starting to get those factors into the equation, into the discussion with employees. And it may well be that the single greatest accomplishment of the whole coalition-purchaser movement will be an educational vehicle, to bring all this set of messages home to the potential users of those messages: the patient and the individual corporate purchaser.

From this sense of choice and strategy and all the rest of it has come the movement, the evolution, on the part of the individual companies, from single-shot approaches such as "I'm going to be involved with health planning" or "We're going to have a second-opinion program", "We're going to have a bigger deductible and that'll solve our problems"--from that naive but understandable sort of knee-jerk set of reactions of the, oh, 1977 to '80 period, you might say--to the point where they recognized they had to have a strategy, a healthcare cost-management strategy, and must begin to integrate their activities dealing with all three legs of the medical care stool, utilization, reimbursement, and capacity. Just grappling with any one of those meant the dollars flowed out in another direction. You really couldn't handle the system, even within a small community. And that strategy had to involve a set of things that you could do internally, such as benefit design, such as corporate policies; and externally, where you still had unilateral control,

such as where do we give corporate contributions?--not automatically giving them to the local hospital any more; maybe using what was always the annual contribution to the hospital for the establishment of a hospice, a competing delivery mechanism; and the way we educate people who serve on hospital boards--things of that nature, external but still over which we have control; and finally the third locus of activity, which is those things that are best done through collective action: and that's the coalition; and that's the development of alternative delivery systems, multi-employer utilization review programs, private-sector health planning vehicles, multi-employer data systems, all of that set of activities. And again I come back to the catalytic, educational role, which is absolutely essential to the whole set of activities we're talking about.

This thing that's being called a "coalition" (which I must say is a bit of a misnomer on occasion; not all is sweetness and light within the coalition movement) really does have two models: the purchaser model, which can be either all-business, or business with labor and government the other purchasers, government as employer, government as public program purchaser; or the multi-party model or all-party model or hold-hands-around-the-table model, which includes the insurance carriers, the docs, the hospitals, and so forth. And there isn't any set number, but there are roughly a hundred of these things up and running in the United States right now. Doesn't sound like a whole hell of a lot. There were <u>none</u> four years ago; therefore it is rather a lot. They're increasing at roughly three a month, in terms of opening and being ready to do something, and another four or five a month where people in communities are saying, "It's time to start to develop one of these things." It's rather a lot, and particularly when you consider that in the last couple of years, business in the United States has not been looking for a whole lot of new vehicles to spend money on, just for the heck of it. And in the last three years alone over one thousand major companies have paid to participate in these local groups. That number is going up all the time. If you were to say there are about a hundred, hundred and ten of these right now, some 72 of them are purchaser-only models or have 70% or more of their members as purchasers. So no matter how you cut it, you can certainly see where the focus of activity is: the "oomph" is coming from the purchaser side.

One of the critical vehicles for a coalition is building up the power base on the demand side comparable to where it's been on the supply side. The sources of development for these organizations range from individual companies--San Diego is an example of that--to local associations, such as the group in the Philadelphia metropolitan area that grew out of a Chamber of Commerce there; and the New York Business Group on Health, the Chamber there, the medical society, and local associations; to health systems agencies, sometimes looking for work and other times genuinely looking for vehicles to continue a very healthy relationship that has developed with business leaders on planning

boards. And Portland, Seattle, Vermont are quick, off-the-cuff examples of HSA-stimulated activities. And there's an aspect of that that is very important as well: some of the others that were not started by HSAs have health planning as one of their principal endeavors.

Insurers have been involved somewhat (the Health Insurance Association of America, particularly, pushing in Maryland and Milwaukee and a few other places), where part of their reason was a desire to be involved with or to stimulate more state rate-setting from the standpoint of the commercial carriers, the Blues obviously having a slightly different view of state rate-setting but nonetheless being involved somewhat with coalitions in Oklahoma and a number of other places. And then national organizations--our group has a program for providing technical assistance to coalitions and starting them that we began five years ago, when we were just working with one, and we've built up the involvement to the point where we're involved in about twenty-five or so.

The Business Round Table Health Initiative is an information source. The AMA and the AHA and the HIA and the Blues each have an office of coalitions (of one title or another, but that's the function). So you can see that there's a set of national organizational activities sort of spurring this on now, or protecting their interests, or both. Foundations: the John A. Hartford Foundation has been far and away the leader and innovator in this field, providing funding for the group in Utah, and in south Florida, on an institutional basis, and in New York on a project basis, helping the New York business group develop a small business project. The Robert Wood Johnson Foundation has thrown its hat in the ring right now, or perhaps more appropriately the American Hospital Association's and Blue Cross's hats in the ring and the Johnson Foundation's money in the ring. And the Connecticut General Corporation and INA now have programs sponsoring coalition projects. It raises some interesting questions, because there's no doubt that some of the impetus behind foundation funding, other than the Hartford Foundation's, has been to influence the shape of coalitions, not just to facilitate the development of coalitions but to guide it towards a model that they felt or their sponsors felt was the appropriate one. And, as you can tell, that's obviously the multi-party versus the purchaser model.

And finally, the government itself has been a significant instigator of these coalitions, with Governor Graham in Florida taking a very personal interest, creating a political coalition with other purchasers, because he knew, as the largest employer in the state of Florida, that he was going to have to be doing something and he wanted some allies, and created a coalition with chief executive officers in the private sectors. And now the state of Florida is a dues-paying member of the coalition. And in Utah it was the state legislature, it wasn't the governor; in Iowa, it was the governor with the governor's commission on

health care costs and a business coalition. Now there's a whole bunch of things going on in Iowa.

Let me move from sort of this profiling, 'cause you can pick up on that to whatever degree you want with questions, to hitting a couple of the more policy-related issues about coalitions, and then toss it back to you. Coalitions are successful if they continue to exist and meet the needs of those who are members of the coalition. There are plenty of people in the policy analysis world, in the health policy world, who are running around saying, "Prove to me that these things are worthwhile!" And that is nonsense; nobody has to prove to anybody else that they're worthwhile. If the members think they're worthwhile, if they are meeting the objectives that the organization established, they are, by their definition, worthwhile.

It is also possible to see, even at this very early stage, some rather clear outcomes in terms of legislative development, such as in Massachusetts and in Iowa, beginning to see networking of coalitions, such as in California and North Carolina and Iowa. You're beginning to see, for instance, in Ohio, the Toledo business group on health becoming in essence the critical force in certificate-of-need decisions, including even getting the state, for the first time ever, to go back on a certificate-of-need decision and tell a hospital that in fact it could not expand.

We're seeing more and more groups grappling with this adversarial question. How adversarial does the coalition have to be? Or does it have to be at all? It's a question that is used from time to time to attack the purchaser who doesn't let the doctor or the hospital participate in the coalition. The medical side obviously takes the position that since it's their business no serious change can come about without their being a critical actor. The purchaser's response is, "Indeed. You are a critical actor. But we have as much right to have our purchaser group as you do to have your medical society or your hospital council, to which business-people, as far as any of us can figure out, have never been invited. And so if you'd like to put some business leaders on the licensure committee of the medical society, we may feel a little bit more inclined to invite some of you to be on our board." By the same token there are plenty of examples where a multi-party coalition is doing a terrific job and making some real progress. We believe very strongly that the purchaser model provides a healthy catalytic role in society and ought to be very welcome. It should not be mandated by anybody, by our organization or anybody else, but it should not be attacked as being inherently wrong or unethical, as it often has been.

The single most critical thing that's going on with all of these business groups and with the rest of the purchaser movement that I think is policy-relevant to many of you and to those of you who are actually in the care-delivery business itself is the change in the ownership of information. It is the increasing availability of price- and quality-specific comparative data that will enable the purchaser, be it a coalition or individuals, to

educate the individual where to go for care--and make no mistake about it, that education is going to be linked to benefit redesign, economic incentives. It is not going to be, "We'll pay 100% for you to get care anywhere"; it's not going to be, "We'll pay 80% if you get it in the hospital and 50% if you get it outside"; it's going to be, "We'll pay 80% if you'll get it at any one of these places and it'll be zero or 50% if you go anywhere else." There will be behavioral change predicated on the change of ownership of information.

At least we believe so. Many of your confrere in the hospital industry do not believe so; they are doing their best to hang on to every piece of data that they can hang on to. And I can't help but get something of a chuckle out of the reaction on occasion. I think you might find this interesting. An editorial in Modern Health Care a couple of weeks ago, commenting on a speech that I gave in another setting in Chicago two weeks before that to the [American] College of Hospital Administrators meeting, made the following comment, because we'd been talking about access to information. They said,

> What Mr. Goldbeck apparently fails to recognize is that most hospital managers are better trained and have more negotiating and pricing experience than the power-hungry benefit managers for whom he's working. He forgets that hospital managers will be negotiating with every employer in their markets, and like all sellers, they will know more about the market than any buyer, who is only in the market once a year or so. Information is power, and Mr. Goldbeck thinks his members can demand every bit of data a hospital owns. Sorry, but you're dealing with private corporations for the most part, not government agencies. And hospitals will be extremely reluctant to give data to any of their customers or competitors now that they must bid for business themselves.

I want to thank Modern Health Care publicly for that. There is no amount of money in our budget this year or any year that could pay for public relations like that. It is the essence of the change in the ownership of information; it is the essence of why there are coalitions, some of which are adversarial; and it is the essence of why business leaders are no longer going to roll over and sign blank checks for the health care delivery system. We can, and I do believe we will, increasingly work collectively in a responsible, ethical fashion to improve accountability and to improve the appropriateness of the health care delivery system.

I do not believe you will find, except in the rarest of instances--and that's going to be an uninformed instance--purchasers, employers, seeking to buy cheap. Fortunately one of the things that has been learned in the last three or four years, in part by dint of the coalition movement, has been the

incredible value of having healthy workers, not just in reduced health-care costs *per se* but in the related costs of absenteeism, turnover, and all those other factors. Where employers have, through coalitions, access to better comparative data, they have not bought cheap. They have not advised their employees or dependents of retirees to buy cheap. They have tended to negotiate better; they are informing people better; and people are behaving far more rationally, because they have some information upon which to base behavior. They may be cutting out the most expensive providers if there turns out to be a relationship between the high price and apparently unnecessary utilization once you start to ask questions. And they are not buying into the very lowest-priced providers, because there's a suspicion that they can't be sure that the lowest price has enough quality. And they're emphasizing choice among those that tend to be more in the mid-range, if you will.

We believe very strongly that there is more than enough room, economically speaking, in the medical-care delivery system today, even if you don't add new dollars, to provide needed care for everybody in this country. What we cannot afford to do is fail to come to grips with the system, because the results will be far worse if we allow the *status quo* to continue than they ever will be by any degree of change we might perpetrate through coalitions or other aspects of the purchaser movement. Thank you very much.

REACTOR PANEL, Thursday afternoon, May 19, 1983

STEVEN FOLDES. I have a question that applies both to Mr. May and to Mr. Goldbeck. A great deal of the entire approach, which Mr. Goldbeck just articulated with considerable passion, toward moving in the direction of more informed, rational kinds of decisions in choosing health care depends on not only cost information but also quality information. After all, whenever we buy anything, a product, we always tend to make a judgment between price and quality. There is tremendous interest (and coalitions are a perfect example, in my experience) of obtaining and releasing and using the cost information--price information. But where is the quality information, and how do you propose to provide the kind of information on which people can make informed decisions without any quality information? And I ask that question fully in recognition of the fact that quality information in health care is a terribly difficult issue to deal with. Nevertheless, it is essential to making any kind of rational judgment--unless you take the basic approach, that with certain licensing boards, with a practice profession being basically a fairly well professionalized service, you can assume that with occasional, minor exceptions, the quality is pretty much the same. I doubt that you want to make that assumption, given the fact we've recently recognized that the costs are so dramatically different that certainly the quality must be as well.

JOEL MAY. Well, I don't know how to measure quality. I don't know any ordinal or cardinal or quantitative measure that leads one to a clear-cut decision that this is more quality than that is. Bill mentioned data. And in New Jersey we have these uniform bill patient summaries that I talked about in my presentation, which have all the information on everything that went on for every patient in the state, by doctor, by hospital. And in our analysis of them I can make unambiguous statements about whether this patient got more or less, or whether in this DRG Dr. B uses more or less than Dr. A. I can make those kinds of quantitative statements. But I am sure that I cannot judge, nor have I ever met anybody who claimed to be able to judge, for everybody else, whether more was better than less. Even the physician committee that we have, that's supposed to be translating my quantitative results into quality-judgments, disagrees among itself. I suspect that there is a bottom level below which quality is abysmal. I suspect that there's vast band within which quality is acceptable; and I doubt that there's anything above that.

WILLIS GOLDBECK. I certainly wouldn't disagree with that comment. Let me make a couple of points. And you're right, number one, that quality information is tough to get, there is no simple answer, and there is no reason in the world to assume that professional licensure or anything of that nature is a surrogate for quality--in any field, let alone in medicine. But we do not have to do nothing because of that, or throw up our hands in sort of a hopeless state. First of all, we have to start from the

fact that we make all purchases in the system now on the basis of no information. So moving to some information isn't exactly going in the wrong direction. Second, there is an increasing body of information on the relationship of certain practice patterns and utilization to outcomes, such as the volume indicators vis-a-vis cardiocatheterization and open-heart surgery. There are now some in the domain of certain OB-GYN procedures. There is more and more investment that is now being made and certainly will be made in outcomes-validated medical standards. There is an entire body of case law which nobody has bothered to look at from a quality standpoint that relates to what are considered to be the standards to prove completeness of treatment. There are also the various kinds of studies, such as Wennberg's and others, that show at least where significant problems are.

And I think that leads to my major point about how this kind of information really is best used, and that is, it provides you with a vehicle for targeting action and educating, not for writing finite prescriptions. It would be totally wrong to say that because someone has a longer length of stay they are *ipso facto* doing worse-quality care. But if you do have the kind of data that New Jersey does, when you see a physician, as I just looked at in one hospital not in New Jersey, working in six months in over fifty DRGs--in six months--and in all but two of those DRGs averaging thirty to eighty percent greater length of stay than the average, even within that institution, of other physicians doing each of those DRGs, you damn' well know who to call to start an assessment of whether that is appropriate or inappropriate. You no longer are forced to look at the hospital and say, of the hospital aggregate data, "There's a problem but I don't know what to do about it." You won't have to say any longer, "God, the doctors (plural) in that hospital must have a problem." You know at least where to go and start to target, and to that extent, I think this kind of information is a tremendous tool; and the presence of the utilization of data will improve both the availability and the quality of the data that comes into the system.

LEONARD ROBINS. Mr. Goldbeck mentions the scholars who've asked whether the coalitions have been worthwhile and what they've accomplished in the aggregate and responded that who gives a damn as long as the members of the coalition are happy? And that's certainly true in terms of functionalist theory or organizational maintenance, but obviously for students of public policy I'd like a little more elaboration, as you proceeded to do. After saying "Who cares?" you proceeded to try and give some case studies. Do you suppose you could repeat how we might systematically assess the validity of coalitions as vehicles for cost containment?

MR. GOLDBECK. Let me take that in two parts. Let me be real explicit. I don't find any value to Sapolsky's critique at all. It was a series of interviews with under a hundred people in the whole United States, starting from the preconceived notion

that for a corporation to have an involvement in health care and to be serious about health care, the chairman of the board had to have made an explicit commitment. And there is no relationship there. It is nice to have chairmen paying attention. Sometimes that's the catalyst and sometimes it's not. But there are countless companies that are doing all sorts of things all over the country, committing corporate resources; sometimes they're doing them well, sometimes they're doing them terribly, but they're doing things, and the chairman of the board hasn't paid any attention to it yet. And there are other cases where the instigation has come totally from the personal direction of the chairman. So you can't draw that analogy, let alone for the nation, on the basis of a few interviews. And it also was a long time ago. So I think you can put that little piece of work to sleep in short order. And first of all there weren't any coalitions to speak of when that was done and now there are over a hundred of 'em. I believe among the things he said was that business would never take on the medical community. Well, I can tell you that my mail from the AMA and elsewhere suggests that they feel they're being taken on; whether successfully or not remains to be seen.

As far as how the policy world can assess these things, they have the disadvantage of being private rather than public agencies. So they don't have the reporting process. They don't have to tell anybody anything, really. And they don't fit a nice, tidy posture of a group that has a public agenda, if you will. By the same token, there're getting to be enough of them now, and a few of them are getting to be old enough, that they are, I think, going to lend themselves to some comparative analysis comparing what they do against what they set out to do. What I'm leery of is some form of an academic assessment that says there are a hundred coalitions and they haven't saved anybody any money yet all over the country; therefore they are failures. Because that's setting up a criterion that they don't have. That isn't their measure. And so I think there are ample opportunities to look at a variety of groups. Take the fifteen coalitions that have set up an objective to have an influence over health planning, and look over three to five years and find out if they had an influence over health planning. But don't go to the one whose purpose is to be an educational forum or a utilization review group and then say, "They didn't do anything about the capacity in the system; therefore they're failures." Because that's not the kind of criterion that they're operating under. They're different.

PHILIP HAAS. Over a decade ago, Martin Feldstein suggested that the ultimate method to contain cost and ration care would be through having benefits re-aligned so that you would have to exhaust a portion of family income before they would kick into play, ten percent or thereabouts. I'm wondering how far, Mr. Goldbeck, you and those who are behind these coalitions would be willing to go towards that kind of a benefit structure, particularly if your objective about information on quality and

price were met. And also to ask our philosopher how you would feel about that kind of a benefit, where there is a conscious choice and where the allocations and rationings are made by a family individually according to what resources it has, assuming that you have federal, state, or other, private benefits that would kick in above x% of family income.

MR. GOLDBECK. Well, as a practical matter there is a fairly strong movement towards increasing cost-sharing, in various ways--front-end deductibles and other co-payments throughout the design of the benefit package. Companies that four or five years ago thought they would have no chance at moving away from first-dollar coverage are doing it with rather considerable success today. It certainly isn't everybody, but it's happening much more than virtually anybody thought would be possible. It is not happening to the level of a significant percentage of income being the deductible. I mean, it's considered a big deal to go from a one-hundred- to a two-hundred-dollar deductible. And I think you can question the significance of that kind of a change. There are a few companies that are in the process of putting a percentage of income as the deductible, within their own benefit packages. That's going to be watched very carefully by a lot of other companies, both from its labor-relations/industrial-relations standpoint and from its health care impact. We don't know very much about what the impact of that would be. It's an all-very-nice theory. And I guess it's way beyond theory; it's reality that the larger the number, the less will be the utilization after a certain point; I mean, how much of a punishment process do you want to make it? The Rand study is at least suggestive that the well-employed population will not miss very much needed care, and they will reduce utilization. It's much less clear on what would happen to lower-income groups. And that's the closest we have to a study on it. We really don't have anything else.

I think you can say the trend is toward more economic incentives throughout the benefit package rather than larger dollar impact at the front end, because I think more and more employers, as they develop these strategies, with or without coalitions, believe that they want to change behavior in an informed way rather than changing behavior only because you keep somebody out at the gate. So it's better to have you be able to get into the gate for the right things, and be steered by information and economic incentives to the appropriate care setting, so that certain ambulatory procedures will have a very heavy economic incentive to use them, and they'll be very explicit as to which kinds of surgery, not all kinds. When does a hospice benefit begin, and if it doesn't, why not, and what are the economic implications of continuing to have terminal care in an acute-care setting that's unnecessary? And so forth. I think that's the trend you're going to see.

DANIEL WIKLER. I'd raise three points, actually: one thing, the problem of what pattern of rationing the poorest would

choose, if they had to do this rationing, which I fear would be one that we would find unacceptable. And the second thing is that even if we graduate this by choosing some percentage of income, or of wealth, still the amount of disposable income for the poorest is much smaller relative to need, and this probably increases the chances that the amount that we'd require of them as a co-payment or deductible would come out of other needs that anyone else would consider urgent, and I think that's wrong.

But the deeper point, I think, when we think about shifting some of the costs onto the individual to make them better consumers, is to inquire back again, to ask why it was we thought that subsidization of their medical expenses was a good idea in the first place. If you think, for example, that the reason it's a matter of social justice that individuals have access to medical care is that without it you don't have equal opportunity for success in life, competition in the economic order, and choice between a wide variety of life plans, it makes no sense whatever to hobble people financially so that although they may be doing all right with medical care, you've taken away their opportunity to pursue other education or in other ways secure equal opportunity. So I think that transferring too much responsibility to the individual for making these economic decisions essentially undercuts the whole goal of the initial thrust for giving them health benefits, which doesn't make any sense to me.

MR. HAAS. We have to begin rethinking that whole question of health benefits, because, again, of all the wealthy employer families and "cafeteria" compensation plans and that kind of thing. If you apply the same resources towards my paycheck as you did toward health benefits, particularly if those benefits become taxable, then there are some resource allocations and at least some consumers such as I might feel more qualified to make that decision than anybody else.

MR. WIKLER. Yes, certainly. I think once we move away from the poor, so that there's more disposable income, these problems are much less serious.

MR. GOLDBECK. All of that kind of choice-making has another wrinkle to it that none of us has touched on yet, at least during the time that I've been here, and that's the adverse selection issue. Aside from the fact that it meant good business for the medical professions and industries, one thing that insurance did do was spread the risk. And the more you go to choice-making, the less you spread the risk. It obviously is very valid from a whole lot of standpoints. But if you end up with everybody being able to pick either insured or self-funded or whatever delivery system that is most suited to their medical utilization needs at that time, then those who have greatest needs, which usually equates to those who have the fewest economic resources to devote to those needs, have no place to turn, whether they are from the employed sector or from the poor sector.

MR. FOSTER. I feel I ought to get to ask one question. I'd like to ask Mr. Goldbeck about the opposition of substantial elements of the business community, including the Chamber of Commerce, to proposals to cap the tax-deductibility of employer contributions to health insurance, and what the logic of that is.

MR. GOLDBECK. I thought that might come up at some point. I think there's something you've got to understand. Employers are never going to voluntarily support the taxation of a benefit. Period. The end. It's just that simple. The benefits are part of the negotiated compensation system. That's with or without unions: employer to employee, regardless of whether there is a union in between. And they don't want, any more than any other business does, government to be defining how much of any one of those benefits is considered appropriate or inappropriate. So you have an automatic negative reaction.

Now that is not a health policy reaction, and that's an important distinction. There are a fair number of business-people, and there are many in our group, who believe that the tax cap is eminently reasonable, from two or three different standpoints, either as a health policy decision, because it makes sense not at least to continue to provide a public-sector support for people who don't need it in this area, but also from the equity standpoint that you [Mr. Wikler] spoke of. The Chamber of Commerce and other business groups go to Congress and tell them that this nation can no longer afford to spend tax dollars on the poor. And they turn around and say, "But you should also continue to spend tax dollars *ad infinitum* on us." And that's a rather heavy inconsistency. And more and more employers are noting that and feeling uncomfortable with that inconsistency. So it's a clash of values within the employer community. It stems from that basic "we don't want to tax any benefit" position. And it's one of the toughest things that we have to grapple with right now and I'm not comfortable with it either.

MR. FOSTER. The hour is late and I'll recognize only one more question and I see Odin Anderson's hand.

ODIN ANDERSON. If that is true, then with the combined pressure of employers and employee unions, we should forget about our built-in tax benefits.

MR. GOLDBECK. No, sir.

MR. ANDERSON. Well, where's your constituency?

MR. GOLDBECK. This may be one of those fascinating little political issues where you don't have to have a constituency. And I'm not suggesting it's necessarily going to pass this year. Let me draw the picture for you of the reconciliation conference. It's 1:30 in the morning--

MR. ANDERSON. Reconciling whom?

MR. GOLDBECK. The budget process in Congress. The reconciliation conference, when the House has passed its budget, the Senate's passed its budget, and you go to conference: it's called a "reconciliation conference" for the budget. It's 1:30 in the morning, they've been meeting for five days, they're looking at a presidential veto and Christmas. And they have just spent eight hours trying to figure out how to take four million dollars out of a program for the poor. And somebody says, "We can put $2,800,000 or $3,200,000 or whatever on the plus side of the ledger, right now, with one stroke of the pen, and nobody gets hurt." Thank you; twenty-one to nothing. Next? No lobbyists, no constituencies, no nothing. But a lot of decisions are made that way. I would say that the chances for a tax cap within the next three years, the odds would be 75% in favor of the tax cap. [comment, inaudible] We spent fifty years building this mess; it's going to take a lot longer than three years to straighten it out. I'm not sure--I mean, it may happen this year. [another comment, inaudible, and laughter] Well, I just gave you my estimate, that's all.

MR. FOSTER. Okay, I'd like to thank all of the speakers. It is getting late, and I appreciate your attention.

HMOs AND COST CONTAINMENT: EXPERIENCES IN MINNEAPOLIS-ST. PAUL AND CHICAGO

RON ANDERSEN. The Center for Health Administration Studies and the program in hospital administration of course take as primary goals and functions the dissemination of information and the teaching function. But we're also in the business of trying to produce information and knowledge as well. The symposium, from time to time, presents a good opportunity for the center to discuss one of its own research programs.

The theme of this symposium having to do with cost constraint and regulation and the response of the private sector does provide us with an opportunity, I think, to contribute significantly. Our HMO project is an excellent opportunity for us to share with you some of our on-going research. The study in the Minneapolis-St. Paul and Chicago areas deals with the factors associated with the development of Health Maintenance Organizations. It's funded by the Kaiser Family Foundation in Minneapolis-St. Paul, and the Chicago effort is supplemented by grants from the Chicago Community Trust and Blue Cross-Blue Shield of Illinois. The staff of the project will be presenting its findings today. Odin Anderson is the principal investigator; Terry Herold, over in the corner, is the project director. Other staff members include Bruce Butler, who's also an MBA student in the business school; Claire Kohrman, who is working on a Ph.D. at Michigan State; and Ellen Morrison, who's a Ph.D. candidate in our department of sociology. At this point I'll turn the session over to Odin Anderson.

ODIN ANDERSON. Thank you very much. We're very pleased to have this type of audience, to have a sneak preview of our HMO project, because it's our first public presentation. We're very fresh out of the field, and as I'm sure that as you look into our presentations you will realize (as we will tell you) that we're quite sure of what we're saying and we'll probably stand by them even after further reflection. So what we're presenting to you is pretty much the substance (although very abbreviated, given the time constraint) of our findings from our HMO study. I'll be presenting my colleagues in due course, in the sequence of our topics.

About three years ago, when we became interested in the emergence of several Health Maintenance Organizations in the Minneapolis-St. Paul metropolitan area, seven HMOs had penetrated around twenty percent of the health insurance market of two million people. All of this market had been taken from the prevailing Blue Cross-Blue Shield plan and the private insurance companies. Now the market penetration of HMOs is around 27% and still growing. We asked the questions, "Why the Twin Cities?" and "What impact is the HMO penetration having on the mainstream of the health services other than taking customers away from the prevailing health insurance carriers?" The Kaiser Family Foundation, Menlo Park, California, was also interested in finding out,

and by April, 1981 we were given a grant by this foundation to do some intensive exploratory work to get a feel for what was going on, beyond anecdotes, magazine articles, and newspapers.

As we got into the Twin Cities project we encountered justified criticism of the limitations of a one-case approach from which to generalize for the possibility of developing HMOs in other cities. The Twin Cities have certain characteristics of population, business, and industry, and a "progressive" history to the approach of social and health problems. Because we were located in Chicago it was suggested from some prestigious quarters that we also include Chicago as another reference point, for this metropolitan area was seeing a great deal of ferment in early 1980, analogous to that in the Twin Cities in the early 1970s. The market penetration is now about 5%. The two areas were both responding to the cost escalation of the health services, but the Twin Cities responded, as a community, ten years earlier than did the Chicago area, although the cost and expenditure indicators were the same. The long and short of it was that about a year after we started with the Twin Cities area we were able to deploy our staff to the Chicago area as well, with funding from the Chicago Community Trust, Blue Cross-Blue Shield of Illinois, and, again, the Kaiser Family Foundation.

A greater contrast between two urban areas is difficult to find, enabling us, I believe, to get some insight into the "generic" minimum number of elements that need to be present to make possible the emergence of multiple HMOs, and a concept of competitive options that facilitate their growth. I will give a brief overview of our research approach and the major characteristics of the two areas that facilitate or hinder HMO development. The research staff will follow with specific sectors we have selected for analysis, after which I will close with a brief summary statement to tie things together. The specific sectors are (1) the employee health benefits marketplace (Bruce Butler), (2) the medical community (Claire Kohrman), (3) the hospital community (Ellen Morrison), and (4) the HMOs (Terry Herold).

We have developed three data bases:

1. The demographic characteristics of the two areas, the business and industry characteristics, occupational structure, white collar-blue collar characteristics, educational level, and related data, so as to give us some idea of the marketing potentials. We have also collected data on the hospitals, physicians, trends in use of services, sources and destinations of funds, and through what components of service. All this we plot over time starting at least with 1960 to show changes before and after the appearance of HMOs until 1980.

2. Personal and taped interviews with leading informants from hospitals, the medical profession, employers, insurance agencies, consumer groups, and regulatory agencies. We did 140 interviews in the Twin Cities and 160 in the Chicago area

averaging from 45 minutes to an hour each. These interviews enabled us to get a great deal of insight into the attitudes and perceptions of the major decision-makers, gauge their level of awareness and knowledge, and enhance considerably the hard data we collected. We followed a long-standing axiom in sociology that what people regard as real is real in its consequences.

3. A rather thorough case study of the seven HMOs in the Twin Cities and the eight in Chicago from inception to the present time, to obtain a profile of the stages of development, sources of starting capital, initial marketing groups, recruitment of physicians, and (not to exhaust the list) relationships with hospitals.

Problem-solving Methods and Styles

The methods and styles of attempts to solve metropolitan area-wide problems from sewers to health services are almost at opposite poles in the two areas, but still basically within the framework of the American political process of interest-group politics. The Twin Cities style is a relatively easy creation of consensus based to a surprising extent on reliance on facts bearing on the problem. Because the Twin Cities population is very homogeneous, consensus is easier to arrive at than in the highly heterogeneous population of the Chicago metropolitan area. Hence the Chicago method and style are largely confrontational politics (which, of course, the late Mayor Daley was able to paper over, but his two successors, Jane Byrne and Harold Washington, illustrate what I mean). It helps considerably that the Twin Cities population is smaller--two million--whereas the Chicago-area population numbers seven million, making it much easier in the Twin Cities for top leaders to know each other. There is only one major business club, i.e., the Minneapolis Club. In Chicago, there are several, the top one being the Chicago Club. Also, the leading companies in the Twin Cities have their home offices there, e.g., Pillsbury, General Mills, Honeywell, Control Data, and 3-M. Finally, but hardly ending the list, there is little of the suburb-central city conflict that is true of the Chicago area.

Twin Cities consensus is exemplified by the creation of the Metropolitan Council in 1967 by the state legislature as an umbrella agency for a seven-county area, to be concerned with problems that transcend the two cities, counties, and townships. The Council has tackled successfully area-wide problems of sewage disposal, super-highways, and parks. Now the Council is deeply involved with the health services, particularly the hospital bed supply, and is backing the concept of competitive options between delivery systems as a means of slowing the rise in the cost of health service.

The Twin Cities initiate concern with area-wide problems through what has become a rather structured means of consultation among the groups at interest with the keen participation of the

business community, the health service leaders, consumer groups, the Metropolitan Council, as mentioned, and the Citizen League. The League was organized in the latter 'forties by leading citizens and now has a constant membership of 3000 people with a technical staff to produce factual information on particular problems that have aroused the concern of the community in general. The current leading problem is that of the expenditures for health services. This structure and process might be called "structured pluralism", and that is, I believe, a characteristic peculiar to the Twin Cities. Perhaps Seattle, Rochester, New York, and Cincinnati operate on the same principle. In fact, as my staff and I roamed, as it were, through the two metropolitan areas we became very aware of the differences through our interviews. Having lived in Chicago for over twenty years myself, I was so struck by the seeming calmness and rationality of my Twin Cities informants that I felt they must be ingenuous if not naive. I have done a lot of interviewing in Norway and Sweden, and I was struck by the similar styles of discussing social and political issues. It is a middle-class area with middle-class problems.

This brings me to why this method and this style of approaching problems are so different from those in the Chicago area. A student of American political history by the name of Elazar helped me here in his _Cities of the Prairie_. The upper midwest was settled first by New Englanders who were accustomed to town-meeting democracy and were very moralistic in their view of social responsibility, and issue-oriented. They were also, of course, clever entrepreneurs and opened up the country commercially and politically. These early settlers then provided a natural matrix for the next wave of immigrants from Scandinavia and Germany, who were hard-working and puritanical and had a sense of community effort, and not necessarily through government either. Their cultures fused easily, the New Englanders being the early leaders who later absorbed the Scandinavians and Germans. There was thus established the political style that persists to this day.

Chicago, of course, because of a very different set of historical circumstances, became a hetereogeneous, somewhat brawling, fast-growing metropolis, the bridge between the east and the west. The early settlers were also northeasterners, but they were engulfed politically by the Irish and their extended-family political propensities. Chicago, then, does not have a structured method of initiating and discussing area-wide problems, and it takes some initiative, craftiness, and time to get something rolling. Chicago is more likely to use the political structure to introduce issues; the Twin Cities are more likely first to use the private sector, which then begins to involve the politicians.

I do not wish to exaggerate the differences between the two areas, and I hope I have not done so; let me emphasize, then, that within the American political process the Twin Cities and

Chicago are within the same framework but are possibly extremes and polar types. The medical profession, e.g., in the Twin Cities, did not by any means embrace group practice prepayment readily, but did not have the same intense hostility true elsewhere. The physicians in the Group Health Plan, a consumer cooperative organized in 1957, were not denied membership in the local medical society, nor did they have undue difficulty in obtaining hospital appointments, although they were regarded as relatively low-quality physicians.

If you like riotous pluralism, Chicago is a much more exciting city than the Minneapolis-St. Paul area. If, however, you like an orderly, relatively calm, structured pluralism, then the Twin Cities is your environment. Temperamentally, I prefer the Twin Cities, but the devil in me frequently prefers Chicago.

What, however, are the similarities? In essence the HMOs in both metropolitan areas emerged from the same health service delivery structure, i.e., voluntary hospitals, and privately practicing physicians paid in the main by fees for service. Both areas are acute-care- and institution-oriented. Physicians and patients desire continuity of care. The widening concern is rising costs. There is a variety of sources of funding. In essence the same mortality and morbidity patterns prevail. The normal body temperatures is 98.6^{o} F. and the normal anatomy has a pair of lungs, a pair of kidneys, one heart, two legs, two eyes, and so on. As mentioned, these similarities, however, and the demand flowing from them, are being filtered in different ways through the characteristics of the respective areas. The presentations to follow will elaborate on these observations.

The Health Benefits Marketplace

BRUCE BUTLER. Thank you. I'll be addressing the topic of HMO development within the context of the marketplace for employee health insurance benefits. Several of our speakers yesterday provided us with some fascinating insights on this topic, and I hope that this brief summary of our findings will add to those insights. The employee health benefits marketplace governed the expenditure of approximately fifty-five and one-half billion dollars in 1981, or around twenty percent of the total expeditures on health care in the United States. General market conditions in this industry include a long-term trend of benefits and enrollment expansion, which began at least as far back as the 1940s and continued up through the late 1970s. In addition, the proportion of employers that offer health benefits has increased over time. The industry has become characterized by a high degree of replacement marketing, with customers switching back and forth among competitors rather than entering the market anew.

Health insurance market conditions in the two areas that this study focuses upon, the Twin Cities and Chicago, roughly parallel these general nationwide conditions. Each of the two areas, however, also exhibits unique sets of characteristics,

which have affected HMO development in markedly different ways. I'd like to continue by first discussing the unique aspect of the health insurance marketplace in the Twin Cities: general characteristics of the employer community; employer attitudes towards cost containment and HMOs; and the responses of fee-for-service insurers to HMOs. I'll follow by discussing some of our corresponding findings from the Chicago area, and I'll conclude by reviewing some generalizations that can be drawn from the experience of the two areas as well as bringing up some emerging issues.

Perhaps the most striking aspect of the Twin Cities employer community is its concentration. The metropolitan area is home to a disproportionate number of large corporations, ranking second in the country behind Boston in terms of per capita headquarters of corporations with over ten million dollars in revenues. Even the public sector follows this general pattern, by virtue of the location of both the state capital and the large University of Minnesota campus within the metropolitan area. Business leadership is tightly knit, both professionally and socially, as Odin mentioned. It seems to be derived from approximately twenty CEOs of large, locally headquartered firms who have demonstrated an historical pattern of successful cooperative involvement in community affairs.

These characteristics suggest a highly accessible employee health benefits market, into which new concepts could be easily introduced. In the case of HMOs, however, a sub-group of Twin Cities business leaders proved to be not simply responsive to the HMO concept but actually quite pro-active. In 1972, the Twin Cities Health Care Development Project was initiated by several business leaders in order to advance the idea of pre-paid medical care as a potential long-term remedy for rising health care costs. In addition to regulatory reforms, the development project fulfilled the purpose of familiarizing most Twin Cities business leaders with the HMO concept. Despite the original interest of the development project with cost containment, however, most Twin Cities employers that we interviewed cited reasons other than cost containment *per se* as the primary motivation for their initial decision *to offer* HMOs. Typically, employers in the Twin Cities found HMOs attractive as a means of expanding employees' coverage to ambulatory services but expanding in the least expensive way possible.

While many employers were certainly enthusiastic about concepts such as cost containment through provider risk-sharing, and competitive system reform, it seems that in the early 1970s, few employers actually based their benefits management decisions on these somewhat intangible theories, particularly since HMO premiums were initially higher than fee-for-service coverage. Indeed, a significant number of major Twin Cities employers who were active participants in the development project did not choose to offer HMOs themselves until SHARE HMO became federally qualified and began mandating employers in 1976 and 1977. Unlike

many other metropolitan areas, however, negative opinions resulting from the mandating process were defused by the familiarity of employers with the HMO concept and by the prior successful experience of other local firms. In order to ensure employee satisfaction with delivery sites and HMO types, most of the mandated firms offered several other HMOs as well. As a result, virtually all major employers in the Twin Cities now offer multiple HMOs.

While several major insurance companies were involved in the early planning stages of HMOs in the Twin Cities, HMOs for the most part emerged as independent organizations, which were able to marshal the resources necessary for operation without extensive backing from large insurers. Among major insurers, only Blue Cross-Blue Shield of Minnesota developed a subsidiary HMO, and this organization was a late entry into the market. Instead, many insurers have reacted to HMO growth in the Twin Cities by providing extensive ancillary HMO-related services, such as stop-loss insurance, claims processing contracts, and management of multiple-choice benefits plans for employers.

The response of Twin Cities employees to HMOs has been quite positive, mirroring the general willingness of employers to cooperate with HMO marketing by supplying mailing lists, facilitating group meetings, preparing benefits comparisons, and other efforts. As a result, several firms, such as Honeywell (which we heard from yesterday), report HMO penetration rates of as high as 75%. According to benefits managers, the major perceived advantages of HMOs are convenient locations, reductions in paperwork, and low total out-of-pocket costs. Factors that appear to have made it relatively easy for Twin Cities HMOs to develop attractive products include the area's low travel times, which facilitate the set-up of a highly accessible delivery system, and a set of state insurance regulations that mandate highly comprehensive (and expensive) fee-for-service benefits--for example, the state's extensive mandated mental health coverage. This regulatory environment has undoubtedly made it less difficult for HMOs to compete on a price basis.

In many other metropolitan areas, organized labor has been cited as indifferent, or even obstructionist, to HMO development despite pro-HMO policies on the national level. In the Twin Cities, however, a different picture emerges. First of all, many of the key large firms that set the stage for early HMO market development employ very few unionized workers, owing to their lines of business, such as high technology and retailing, or owing to their location of headquarters in the Twin Cities with plants elsewhere in the country. Furthermore, several Twin Cities labor unions have had active roles in HMO development, including the teachers' and government workers' unions, who played a major role in the formation of Group Health Plan, and the Teamsters and electrical workers, who have cooperated extensively in the marketing of HMOs to their rank and file.

tions and therefore have access to the attention of top business leaders. For the most part, however, employers have tended to focus on cost-containment measures with relatively easily demonstrable results: self-insurance, second surgical opinions, cost-sharing with employees, improved information and control systems, and other, similar initiatives. The strategies and results that Dr. Kaminski outlined for us yesterday provide an excellent example of this thrust.

To summarize employee health benefits market conditions in Chicago, we have found a highly decentralized employer community which has been somewhat resistant to the HMO concept. HMO advocates in Chicago have had a much more difficult job on their hands until very recently. Organized labor has been indifferent to HMO development; and employees in general have only recently begun to respond favorably in large numbers.

Several generalizations are suggested by the HMO development experiences of the Twin Cities and Chicago. The importance of purely environmental factors, such as the degree of employer centralization and innovativeness, the relative generosity of existing fee-for-service benefits, and the geography of the communities themselves, have all been underscored as important marketing factors.

Current fervor among employers regarding cost-containment presents HMOs with both threats and opportunities. Employers are more willing than ever to consider any new program that promises to reduce costs, but they are also more demanding than ever regarding demonstrable results. Furthermore, HMOs in both metropolitan areas are apprehensive regarding the growing trend of increased employee cost-sharing, and self-insured and indemnity plans. HMOs are concerned that this trend might leave them vulnerable to adverse selection, particularly in "cafeteria" benefit plans, where healthy employees can elect low-option fee-for-service coverage in exchange for other benefits. Consequently, HMOs in both areas are exploring the possibility of developing their own low-option plans. Simultaneously, many fee-for-service insurers are seeking to develop closer ties with providers, through preferred provider organizations, utilization review systems, and other means. The ultimate result of these developments may be a health insurance industry in which distinctions between HMOs and fee-for-service coverage become less and less distinct. Thank you.

The Medical Community

CLAIRE KOHRMAN. Physicians are major actors in the distribution of health care. While their fees account for only fifteen or twenty percent of health care costs, they arrange for or "order", as they say, another fifty percent of the health care dollars spent. Furthermore, much of the lay public perceives "health care" and "physician" to be synonymous or inseparable. Therefore, one might expect, and our interviews show, that physi-

cians' perceptions and behaviors have an important impact on attitudes about health care as well as on the development of any change in the health care delivery system in the community. Conversely, in communities with notably different health care delivery systems, one might expect physicians' attitudes and behaviors to be different.

To understand the perspective of each of the medical communities, we interviewed over fifty informants, some medical administrators and many physicians with varying responsibilities. The interviewees were from solo practice and different kinds of group practice, and from fee-for-service and different forms of pre-payment. And in addition to practitioners, we spoke to physicians in institutional settings, that is, universities, organized medicine, and government agencies. Through these interviews we gained insight into the physicians' differences and similarities in the Twin Cities and Chicago.

We found that since the 1950s, each community has had physicians who have been committed and creative advocates of HMOs, as well as those who have been persistent opponents. Most physicians of both medical communities have responded to the norms of their profession as well as reflecting the modes of the practice and decision-making (which Odin spoke so eloquently about) of their community. We will see that within each community, important pre-existing factors, that is, the degree of homogeneity and heterogeneity of physicians and their already established modes of communication and patterns of practice, have strongly influenced their interaction with the development of HMOs. And while the physicians of the two medical communities respond to and reflect as well as perpetuating significant differences in the two metropolitan areas, they also, more than any other sector that we examined, demonstrate similarities that are equally interesting. There are perceptions and behaviors that appear constant in both medical communities.

To explain more fully these medical communities and their relationship with HMOs I'll briefly discuss five of the relevant elements of the medical communities illuminated by our interviews: first, the general characteristics and patterns of practice in the medical community; second, the most important concerns, or those things that worry the physicians of that community the most; third, the medical leadership; fourth, physicians' perceptions and behaviors concerning HMOs, both initially and over time; and finally, the impact of HMOs on physicians. First, general characteristics and patterns of practice in the medical community. We found important and relevant differences in the physicians and their patterns of practice. In the Twin Cities, the physician community, like the rest of the population, is small and very homogeneous. Of the 4756 physicians in the area, 91% are males and most have done at least some part of their training at one of two medical centers: the University of Minnesota and the Mayo Clinic. There are very few foreign medical graduates (14 FMGs per hundred thousand). In contrast, in

Chicago, the physician population is almost 17,000, and is very heterogeneous. There are many more female physicians (14%), and Chicago physicians have widely divergent training experience. Many have trained out of the area. And even within the area, training is at six different, and competitive, medical schools and many small hospitals. The incidence of foreign medical graduates is high, four and a half times that in the Twin Cities (61 FMGs per hundred thousand). Furthermore, in Chicago, there is a suburban-urban split: physicians in the suburbs and central city perceive themselves as different and confront different issues in their practices. Another difference of the two physician communities is a noticeable age difference. Twin Cities physicians are younger--only 20% over fifty-five, and 9% over sixty-five. But in Chicago 25% are over fifty-five, and 12% are over sixty-five; that's twelve percent over 65.

Perhaps even more significant than these important characteristics is the contrast in the two medical communities of their historically different patterns of practice. In the Twin Cities, there has always been an exceptionally high percentage of group practice. While the national average is reported to be 26.2% of practicing physicians, in Minnesota 67.3% of the physicians are reported to be in group practice. Many are in multi-specialty groups, including the world-renowned Mayo Clinic. Chicago is in sharp contrast. The practicing physicians are largely neighborhood-based solo practitioners, and there is a small percentage of single-specialty group practices. Illinois has only 23.3% of its physicians practicing in groups of any kind; and in the Chicago metropolitan area, multi-specialty group practice is very infrequent, and little known. (It is interesting to note here that the type of practice varies considerably between Minneapolis and St. Paul. In Minneapolis there is a very high incidence of both fee-for-service, multi-specialty group practice and prepaid group practice; but in St. Paul, physicians are in solo or small, single-specialty group practices--much like the pattern in Chicago.)

The second revealing element is the most important concerns, or problems, the medical community of each city perceives. In the Minneapolis-St. Paul area, the first concern mentioned is the effective and cost-containing delivery of care, and competition is frequently discussed. However, in Chicago, the consistent concern that physicians speak of is what they call the "two-tiered medical system". That is, they recognize throughout the area that there are two levels of care, one for the large, poor, inner-city population, and the other for the rest of us. They know it is inequitable, and it is costly; but in contrast to the Twin Cities, their concern with cost-containment is noted only in relation to Medicare, and competition is not spontaneously discussed. In the Twin Cities, the twin issues of competition and cost-containment have become code words that enhance unity, whereas in Chicago the major issue of health care for the poor is inherently a costly problem that intensifies fragmentation. These concerns are realistic reflections of the two metropolitan

areas, and suggest one of their profound differences.

The third element, medical community leadership, must be examined because it can be expected to have an important impact on how the medical community can solve problems and respond to change. Again, our questions to the two communities about the perception of leadership revealed important similarities, and also crucial differences. In the Twin Cities, there is a focus on leadership; certain names are repeatedly mentioned throughout the community. Medical societies early on provided information about HMOs and later sponsored them. Furthermore, and importantly, well respected medical community leaders have worked, in the manner of the community, cooperatively with leaders in other areas, particularly in business, to confront problems of cost. For example, in the Foundation for Health Care Evaluation in Minneapolis, which was founded in 1969 as a forerunner of PSROs, physicians showed an early concern about cost, and a willingness, at least, to work with business leaders.

But again, Chicago is different. There's no focus of medical leadership recognized throughout the area. Although those we interviewed in other sectors comment on Chicago's being the headquarters of organized medicine, physicians themselves do not mention the AMA and its local affiliates as important. And although Chicago has five major medical centers, community physicians do not discuss the university centers as resources or sources of leadership, but rather emphasize their competitive nature. The physicians may acknowledge the idealism, skill, success, or power of certain physicians within the centers, but they do not see these as having city-wide implications.

The fourth element, physicians' initial and subsequent perceptions of HMOs, is particularly complex in the two areas because the early exposure to HMOs and subsequent experience with them differed significantly, and thus in some ways their perceptions and behaviors differ signifcantly. But here is what I find interesting. In other ways--other notable ways--physicians are remarkably similar in their perceptions of HMOs.

First, the contrasting histories in the two areas. Physicians in the Twin Cities knew of HMOs early, because of Group Health's early efforts in 1955, but at that time, for physicians group health had a negative image: not good care; socialistic; an experiment; out of the mainstream; they said they employed physicians who couldn't make it in private practice; and so on. But when St. Louis Park Medical Center, a highly respected multispecialty group practice, entered the HMO market in 1972, it changed the image of HMOs for physicians and others throughout the community. Furthermore, physicians' familiarity with and philosophical acceptance of multi-specialty group practice was a crucial precursor. It is very interesting to note that some private practitioners say it was the multi-specialty group practice that actually was the first competitive departure, with its internal referral patterns, and presented the most significant

competition; HMOs, they say, are just a refinment. Many physicians in the Twin Cities have been exposed to the multi-specialty clinic setting in their training experience and, in fact, like others in the community, associate the word "clinic" with excellence: that is, the Mayo Clinic.

In Chicago, on the other hand, few physicians in the 'fifties or 'sixties thought about HMOs, although there was some HMO activity in the area. When Anchor and Michael Reese Health Plan began in the early 1970s, physicians did not disregard them, because they were at major medical centers, but they perceived them as very local, and as not affecting them or the larger community. Furthermore, although some individual physicians in Chicago speak eloquently in favor of group practice, few have had experience with prestigious multi-specialty groups. Often their experience, and thus their association, with the concept "clinic" has been in the out-patient clinics for the strictly indigent in the large city or county hospitals where they trained.

Furthermore, in the Twin Cities physicians understand the HMO concept, and they know other physicians who practice in them, and feel keenly the competition of HMOs. In Chicago many physicians still do not understand the workings of the different types of HMOs; many know no doctors who practice in them, and although they recognize that HMOs are growing, they still report that they feel no competition from them. There is, though, a different, distinctive concern in Chicago: many physicians are concerned about the effects of HMO physicians on medical staff privileges in hospitals. Much resistance of Chicago physicians to HMOs can be traced to concern about guarding medical staff privileges, which seem intensely important in Chicago where physicians often have privileges in only one hospital.

In spite of these numerous differences in perceptions and conditions, strong similarities also emerged among all physicians in both communities. The similarities are in physicians' understanding of their professional role: the belief in the centrality of the doctor-patient relationship and in the crucial importance of professional independence and autonomy. These seem impervious even to the strikingly different conditions in Minneapolis-St. Paul and Chicago. Here are a number of the recurring and persistent perceptions. Physicians generally avow a disinterest in payment. Some say with pride that they do not know what their services cost. It is not part of their role. All physicians that we interviewed expressed some anxiety about quality in HMOs. Although they do not see any present problems, they still feel that they must be ever-vigilant. This concern seems to be associated with the ubiquitous professional anxiety about under-treatment, which seems to be synonymous with "causing harm". (There is much interesting medical-socialization literature about this.) However, those more closely associated with HMOs see quality as less problematic. That is, the closer the HMO connection, the more confidence in HMO quality.

In addition, all physicians are concerned about and talk about the doctor-patient relationship. Even those who support HMOs worry about erosion of this relationship and see it as the key to the best medical care. We found this concern in all physicians, whether they were traditional, suburban practitioners, public health officials, inner-city black activist practitioners, or HMO physicians. It was everywhere. Physicians usually focus on the protection of the doctor-patient relationship to explain their behavior: that is, why they've chosen to be in HMOs as well as why they've chosen to practice outside HMOs. And finally, also in both cities, physicians cite autonomy to explain both their support of and their opposition to HMOs. Those who oppose HMO practice are concerned about direct interference with their practice mode. Those who support HMO practice often report that they have chosen to do so because they see that the public demand makes some change inevitable, and they want to develop something physician-controlled, and if possible physician-owned, to avoid working in a bureaucracy imposed and controlled by non-physicians.

Having discussed these common perceptions and commitments, we can now go on to the final element I'll discuss this morning: the impact of HMOs on physicians. Because the penetration of HMOs is still small in Chicago, the impact on physicians can best be examined in the Twin Cities. There physicians report a general sense of constraint and competition, and also demonstrate specific changes in practice patterns. Most notable are those solo practitioners who, though they dislike HMOs and have resisted joining them, now feel compelled to participate so that they will not be left out. (At least 75% of Twin Cities physicians are now associated with an HMO.) For those physicians already practicing in HMOs, we find the most notable effect to be the often-reported reduction in in-patient hospital days. Furthermore, many have decreased their use of x-rays and laboratory tests--although some, in fact (paradoxically), seem to increase testing. Physicians who have a mix of HMO and fee-for-service practice report what is known as the "spillover effect". That is, cost-containing practices from their HMO practice spill over into the non-HMO practice. And the HMO-watchers (such as we) are watching for yet another effect: the threshold effect. It is hypothesized that when there is a certain percentage of HMOs in a physician's practice (perhaps twenty percent) it will cause the physician to practice in a more cost-conscious manner. These are some of the effects on physicians that we already see clearly in the Twin Cities and are beginning to see in Chicago.

In summary, we find that physicians as a group, in both communities, share many common understandings of their profession. Perhaps in similar situations or settings, they would respond similarly; but in our two areas of study, much is different. In the Twin Cities, the homogeneity reinforces trust and communication networks in an environment already predisposed to collectivism, and the younger physicians' population is more likely to be interested in HMOs. In Chicago, the elderly physi-

cian population, located largely in ethnic neighborhoods, suggests old family physician-patient relationships, those very relationships that are reported to be among the strongest deterrents to joining HMOs.

In neither Minneapolis-St. Paul nor Chicago has the community lacked for strong, ideologically committed physicians who could provide leadership. But in the large, economically diverse and segmented environment of Chicago, their efforts are isolated from city-wide influence and confined to localized success; whereas in the Twin Cities, the sense of community, the ready networks of communication, make it likely that success in one part of the community will be encompassed and incorporated by the larger community in the already established forms.

Finally, we find in response to the dramatically different community and market conditions in the two metropolitan areas that physicians' behaviors differ greatly, and yet their perceptions and attitudes are remarkably alike. There are some physicians in both areas who have been strongly supportive of HMOs, others who have been opposed. In neither area has the medical community provided primary HMO leadership. Although physicians have been essential, and even talented, actors, they have not been directors of HMO development.

The Hospital Community

ELLEN MORRISON. In this century, hospitals have become a central focus of virtually all health care delivery, owing to their ability to concentrate financial, technological, and human resources, and owing to the favorable climate of third-party reimbursement for in-patient care. During the past few years, however, a troubled economy and escalating hospital costs have led third-party payers to seek alternatives to traditional health care financing and delivery. HMOs as one alternative offer hospitals both challenges and opportunities.

This morning I will briefly discuss four topics that have emerged in our preliminary analysis of the hospital sector as particularly interesting. The first is health care market characteristics; the second, the involvement and attitudes of hospital administrators, trustees, and medical staffs; the third, hospital competition; and last, the dynamics and impact of HMO-hospital relationships.

Health Care Market Characteristics

HMOs, of course, are introduced into functioning health care markets. Three general characteristics of a hospital community that affect market receptiveness to HMOs are capacity, utilization, and cost. An examination of hospital system indicators from the period from 1970 to 1980 reveals important differences between the hospital communities of Minneapolis-St. Paul and Chicago on those three characteristics. In capacity, measured by

beds per thousand population, the Twin Cities has decreased while Chicago has increased. Utilization, measured by admissions per thousand, inpatient days per thousand, and average length of stay, has decreased in the Twin Cities, while only length of stay has decreased in Chicago. However, in Minneapolis-St. Paul, capacity has decreased more than utilization, with the result of an increase in hospital occupancy rates. Cost, indicated by expenses per inpatient day, has increased in both communities, although less so in the Twin Cities than in Chicago.

The Involvement and Attitudes of Hospital Administrators, Trustees, and Medical Staffs

The activities and perceptions of the key actors in a hospital community mold hospital decision-making regarding HMOs. Interesting differences between these groups of actors in both communities give insight into the hospital communities' varying receptiveness to HMO growth. Administrators in Minneapolis-St. Paul reported disintegration of the formal collegial network, and the formation of a new genre of administration characterized by competitive management practices. Those practices are evident in corporate strategies such as joint ventures, mergers, and acquisitions. One example is a recent corporate merger of the Metropolitan Medical Center in Minneapolis and United Hospitals in St. Paul. Each of these organizations was already very heavily involved in multi-hospital arrangements, shared services, and management consulting. Twin Cities administrators are keenly aware of both the financial opportunities and the potential threats of HMO development. They have generally taken a pro-active strategy, by initiating HMO development, arranging for staff privileges for HMO physicians, or providing HMOs with space and managerial expertise.

Trustees in Minneapolis and St. Paul can be characterized as very active and influential, both in hospital decision-making and in the community at large. Wishing a policy input not possible on a single-hospital level, board members formed the East and West Metro Trustee Councils. The West Metro Trustee Council of Minneapolis is reported to have a collaborative relationship with the Metropolitan Health Board (that is the local HSA), and to be pro-active. The East Metro Trustee Council of St. Paul is reported to be more re-active and to have an adversarial relationship with the Health Board, especially regarding bed-cutting and hospital closure policies. Trustees have been very supportive of HMO growth in the Twin Cities, although more so in Minneapolis than in St. Paul.

Hospital medical staff members in the Minneapolis-St. Paul area often actively admit to several hospitals. A network of University of Minnesota graduates promotes communication between fee-for-service and HMO-practicing physicians. Physicians also have a generally collegial relationship with hospital administrators, many of whom are University of Minnesota graduates in hospital administration. Although HMOs were at one time poorly

regarded by the medical community, this issue lost momentum when the medical staffs of two prestigious multi-specialty groups became HMO providers.

In contrast to Minneapolis-St. Paul, Chicago hospital administrators can be characterized by long tenure and a wide variation in business acumen. (Of course, the top end of the scale are all with us today.) Chicago hospitals have a history of cooperative planning and shared services almost exclusively facilitated by the Chicago Hospital Council and the Illinois Hospital Association, rather than as a result of smaller consortia of hospitals. Corporate strategies such as reorganization and merger are rare among Chicago hospitals, athough activity has increased within the past few years: for example, the 1976 development of a multi-hospital system by Evangelical Hospital Association, and the 1980 corporate restructuring of Lutheran General Hospital.

Even though the market penetration is considerably lower in Chicago than it is in the Twin Cities, many hospital administrators in Chicago respond to HMOs as potential threats rather than as potential financial opportunities. There are, of course, exceptions: two major medical centers, Rush-Presbyterian-St. Luke's and Michael Reese, formed their own HMOs in the early 1970s; and a consortium of (current count) twenty-nine hospitals is responding as one corporate unit to the State Department of Public Aid's Medicaid pre-payment RFP.

Trustees in Chicago are reported to be less active, and are more often local, neighborhood business and political elite than city-wide elite. There are no umbrella organizations for trustees, which limits board input to the single-institution level. As businessmen and -women, trustees respond favorably to the cost-saving potential of HMOs. However, as hospital representatives, they are concerned over HMO strategies, which may lower census.

Medical staff members in Chicago often admit to only one hospital, which may be considered to be a "turf" to be protected. Physicians report a fragmented medical community, stemming from the presence of the six medical schools that Claire mentioned, and the relatively high number of foreign medical graduates, and the city-suburb differentiation in practice. The single institution that binds physicians to each other and to hospital administrations in the Twin Cities (and that's the University of Minnesota) is absent in Chicago and has not been replaced by any other organizational or social structure. Most Chicago fee-for-service physicians are skeptical about HMO development, and unlike Twin Cities physicians they are not yet threatened by a decline in patient base due to HMO participation.

Hospital Competition

In the last ten years, competition between hospitals has

been increasing both in Chicago and in the Twin Cities. In both metropolitan areas, hospital administrators compete for physicians and patients in order to enhance their hospitals' prestige and utilization. In Minneapolis-St. Paul, health service system competition, including outpatient and health-related lines of business, rather than inpatient care competition, is further developed. Also, the geographic concentration of the population, the consistency of resource availability, and the economic as well as ethnic homogeneity enhance equal-footing competition between hospitals, especially within Minneapolis and within St. Paul, respectively. Area over-bedding and a high HMO market penetration have prompted hospital administrators to take an aggressive stance towards market protection and enhancement by offering HMOs discounts and risk-sharing. Physicians' Health Plan, for example, has discount arrangements with thirty area hospitals.

Chicago hospitals are just now stepping into the ring of health service system competition, evidenced by the recent testing of the waters of diversification. In the early 1980s, both Lutheran General and Mercy Hospital entered into agreements with doctors' emergency centers; and several hospitals report development of wellness programs, quit-smoking clinics, and hospice services. Competition on equal footing is inhibited in Chicago by wide geographic dispersion of the population, great variation in the resources available, and economic, racial, and ethnic heterogeneity of the population and of the hospitals. Respondents explain that the financially stressed inner-city hospitals are over-bedded, while the financially healthy suburban hospitals are under-bedded. Inner-city hospitals are less able to offer HMOs discounts for their business, and suburban hospitals are less willing. Therefore most HMOs in Chicago do pay bill charges.

The Dynamics and Impact of HMO-Hospital Relationships

Certain of the decisions and concerns of hospital administrators in Minneapolis-St. Paul and Chicago are less suitable for a point-by-point comparison. In fact, some of the most notable differences between the two hospital communities are a direct result of the exceptional HMO market penetration in the Twin Cities, and can best be discussed from the perspective of the Twin Cities. This does not necessarily imply a causal relationship between the process of HMO growth and hospital decision-making but rather implies a correlation between current HMO penetration and current hospital decision-making.

The impact of HMOs can be limited to individual services within a hospital, or felt throughout a hospital or group of hospitals. Owing to their stategy of outpatient primary care, HMOs differentially affect inpatient utilization of primary care units in hospitals more than specialty or tertiary care centers. Impact also varies by volume of HMO business. When a high percentage of a hospital's admissions are members of one HMO, the

HMO has an increased potential ability to dominate the hospital's destiny. For example, one Twin Cities hospital gets 57% of its admissions from HMOs, primarily from one HMO. Administrators report concern that the HMO affects services offered in the hospital and places a heavy emphasis on primary care. The hospital is currently trying to build up its private medical staff. An interesting point is that while an HMO may in theory cancel its contract with a given hospital if the hospital is not price-competitive or does not fulfill the care needs of the HMO, our interviews revealed that HMO-hospital relationships are much more complex. An HMO may not want to sever its contact with a hospital, because of historical ties. More important, the ability of HMOs to "broker" patients is limited by patient and physician preference.

Variation in HMO patient volume also affects whether or not an HMO has a direct or an indirect relationship. A striking difference between Chicago and Minneapolis-St. Paul is in the incidence of direct relationships. In Chicago hospitals infrequently have direct relationships with HMOs. They often accept HMO patients through their admitting physicians, and charge the HMOs as they would an insurance company. Administrators report being approached by HMOs with financial contracts, but not, as yet, accepting them. Twin Cities administrators, on the other hand, aggressively seek discounts, which are tied to patient volume, thereby locking in HMO patient business. They also discuss IPA (that is, Independent Practice Association) contracts as "sticky". If a hospital refuses IPA contract terms, the physicians who normally admit both their fee-for-service and their IPA patients to that hospital may, strictly for convenience, divert all of their patients to a hospital that has an arrangement with their IPA.

A final issue of individual hospital-HMO impact is that of cost-shifting. Discounts for HMOs exacerbate adminstrators' perceptions of cost-shifting to the private sector. After Blue Cross discounts and Medicare and Medicaid reductions, many administrators respond that they can neither shift more cost into the private sector nor afford to absorb the cost within their institutions. Also, owing to HMO cost-containment strategies such as same-day surgery admissions, and performing lab tests and minor procedures on an outpatient basis, administrators suspect that average HMO patients have a higher acuity of illness while they're in the hospital, and therefore utilize more hospital services than the average fee-for-service patient.

An issue beyond individual hospital-HMO relationships and impact is that of community impact of HMOs. Whether or not a large HMO penetration affects community-wide utilization and cost is yet to be determined. Gary Appel, president of the Council of Community Hospitals in the Twin Cities, discussed this topic at a presentation to the Chicago Hospital Council in November of 1982. Between 1977 and 1981, fifteen percent of the Minneapolis-St. Paul population joined HMOs. During that time, overall patient

days decreased only two percent. Although HMO patient days decreased thirteen percent, Appel explained that hospitals increased their services to draw patients from outside the metropolitan area and from out of state. Appel reports a sharp increase in hospital revenues during that time, although he does not control for inflation or compare costs across communities. Actually, our data show a 2% decrease in the Twin Cities from 1970 to 1980 in the ratio of the medical care consumer price index to the all-item CPI, compared to a 7.5% increase in Chicago during that same time period.

These figures are confusing, but even if clear community-wide decreases in inpatient utilization and costs could be demonstrated, the question of favorable selection of healthier individuals into HMOs must be addressed before any conclusions can be reached. If favorable selection has occurred in Minneapolis-St. Paul, many respondents predict a decrease in that trend for several reasons, including the fact that the enrolled HMO population is aging and, as the market share expands for HMOs, the risk increases of marketing to less healthy individuals, particular as Medicare and Medicaid beneficiaries become eligible for HMO participation. Clearly, self-selection, both favorable and adverse, needs to be studied in greater detail.

In summary, this analysis of the hospital sector has revealed critical differences between Chicago and Minneapolis-St. Paul on variables that enhance and inhibit the development of HMOs. Among these variables are capacity, utilization, cost, managerial sophistication, and the degree of hospital competition. In addition, factors of reciprocal impact on HMOs and hospitals have been discussed: for instance, the relative importance of HMO patient volume; patient and physician preferences; and primary- versus tertiary-care settings. A final note on the community-wide impact of HMOs was added as food for thought and call for further research.

The Health Maintenance Organizations (HMOs)

TERRY HEROLD. I'm pleased to have the opportunity this morning to share some of the preliminary results from our study with you. I would like to preface my remarks by saying that without the cooperation of the HMOs in both areas, our research task would have been significantly more difficult. In our study we view HMOs within the broader context of the health care system. You have just heard how various important actors in this system affect HMO development and the market for their services. You have also heard some of the striking differences between the Twin Cities and Chicago health care markets. This contextual information is essential in understanding HMO development. Today I would like to talk about the organization and operation of HMOs, and how they are integrated into health care markets. I would like to talk first about the precipitants of HMO formation, and some of the facilitating and impeding factors to their implementation. Once I have reviewed the factors affecting their

formation and implementation, I would like to focus on the patterns of growth and development. Finally, I would like to conclude by examining recent health care market changes and the adaptation of HMOs to these changes.

In this study we first focus on the introduction of the HMO into the health care market and then on the important organizational and environmental factors affecting their subsequent growth and development. We have ascertained three principal reasons for the formation of an HMO. These can be summarized as ideological, entrepreneurial, and competitive. These categories of rationale should be viewed as ideal types, as clearly HMO formation results from a combination of reasons. While elements of these three reasons can be seen in both the Twin Cities and Chicago, none of the HMOs in Chicago has cited competition from existing HMOs as a principal reason for its formation. Anticipated or perceived competition was cited as a dominant reason for the formation of the late entrants into the Twin Cities market, the Physicians' Health Plan and HMO Minnesota. Entrepeneurial reasons were the most frequently cited for HMO formation in both areas.

Now I would like to address some of the factors that have facilitated or impeded the development of HMOs in these two areas. The legal and regulatory climate can affect the formation and growth of HMOs. For example, in 1938 a group of credit union leaders in the Twin Cities wanted to form a pre-paid health plan for their members. This first attempt at forming Group Health Plan was blocked by a legal opinion stating that this option would be in direct violation of Minnesota statutes regarding the corporate practice of medicine. In 1955, an attorney general's opinion overturned this ruling, and Group Health Plan was formed under the nonprofit corporation statutes. Group Health Plan operated under this attorney general's opinion until the passage of HMO-enabling legislation in 1973.

Several HMOs in Minneapolis-St. Paul stated that the lack of early HMO-enabling legislation impeded their formation. Once passed and promulgated, the Minnesota HMO legislation provided a favorable legal and regulatory environment, which included start-up grants and technical assistance. In 1976, state legislation was passed enabling HMOs to require employers of a certain size to offer the HMO as a health benefit option. While this provision was not extensively used by HMOs, it was of significant symbolic importance to employers, and appeared to encourage them to act voluntarily.

Early HMOs in Chicago operated under the Voluntary Health Services Act, which was passed in 1951 at the urging of union health plans. HMO-enabling legislation in Illinois, passed in 1974, contained stringent capital and reserve requirements. While ensuring HMO solvency and developmental commitment, these requirements tended to restrict market entry and subsequent expansion. Twin Cities regulators were less risk-averse in this respect.

Sponsorship is important in providing or acquiring the necessary financial or organizational resources for the developing HMO and in establishing credibility and support in the marketplace. In each of the metropolitan areas we studied, there was one consumer-sponsored HMO. The consumer-sponsored HMOs had problems with initial capitalization and in the subsequent attainment of financial stability. Physician sponsorship played a central role in the Twin Cities HMO development, whereas in Chicago hospital sponsorship was more important. In addition, carrier-sponsored HMOs were among the first market entrants in Chicago.

Management and marketing abilities are critical in ensuring successful HMO development. Organizations can purchase these services; they can develop expertise in these areas from within the organization; or they can hire experienced personnel. While we observe a combination of these approaches in both areas, in the Twin Cities Paul Ellwood and Interstudy played a significant role in providing management and consulting services to several of the developing HMOs. Several individuals trained at Interstudy later went on to key management positions in several of the Twin Cities HMOs. Several locally headquartered insurance companies also provided valuable management and marketing services to the developing HMOs. Later, Group Health Plan played a role in providing consultation and technical assistance. In Chicago, typically some developing HMOs have tapped existing institutional resources for management expertise, while others have acquired experienced HMO managers. The newest entrant into the HMO market in Chicago has entered into a management agreement with a national HMO-management firm. In both Chicago and the Twin Cities, several HMOs have entered the market with an existing or a guaranteed market base: hospital employees, county employees, and others. This has provided them with an immediate source of revenue and a base for further growth.

HMOs everywhere are highly interdependent organizations. As such, to function well they require the commitment and support of various actors involved in health care finance and delivery. In the Twin Cities, Group Health Plan was the target of covert and overt opposition of physicians and insurers. The entry of the St. Louis Park Medical Center and the Nicollet Clinic into the HMO market, however, legitimated pre-payment as an acceptable alternative. HMO physicians in Chicago have had some difficulty in obtaining hospital privileges at several institutions. Historically, the attitude of the Chicago medical and hospital community toward HMOs can best be characterized as "benign neglect". While support was divided within the sponsoring organizations of several HMOs in both areas, organized medicine and hospitals did not officially oppose the development of HMOs in either area. Interest in HMOs by both the medical and the hospital communities has increased over time. This has developed later in Chicago than in the Twin Cities.

Now I would like to share some observations on the growth of HMOs, once formed. We have examined patterns of development across the fifteen HMOs we studied. Our organizational analyses focus on the administrative, medical, and hospital components of the HMO. Not surprisingly, developing HMOs manifest the same organizational dynamics as any other growing small business. Typically the administrative component of the developing HMO consists of a small number of people. Staff-model HMOs generally require larger initial administrative staffs than do group practice, network, or IPA models. Administrative functions previously performed under contract with outside agents tend to be internalized as the HMO grows. Differentiation of function, departmentalization, and specialization increase with HMO enrollment growth. Typically HMOs grow increasingly independent of their initial sponsors over time. In these two health care markets the entire spectrum of medical organization is represented, from the highly centralized medical-staff model to the more decentralized independent-practice-association model.

In recent years there has been increased emphasis on utilization controls such as pre-admission certification, length-of-stay assignments, and others. In addition, these controls have also become more formal. For all models of physician organization, reimbursement arrangements are being examined and modified to provide physicians with increased incentives to control utilization. For years HMOs have instituted varying degrees of control over hospital utilization. More recently there is an increased interest in controlling ambulatory utilization, particularly in decentralized HMO models.

A variety of structural changes have occurred in the organization of the medical component of the HMOs. More changes have occurred in Minneapolis-St. Paul than in Chicago. HMOs in both areas have greatly expanded their accessibility by adding new sites in the last five years. In the Twin Cities, several HMOs have expanded their geographic accessibility by contracting with existing fee-for-service medical groups. Several staff model HMOs have contracted with a number of existing medical groups, thus becoming hybrid staff-network models. With the exception of one staff model and one IPA model, all HMOs have a medical group practice network component.

In Chicago, the majority of HMOs have increased their number of delivery sites while working within the parameters of their original organizational models. Within the last year, an IPA has been introduced into the Chicago health care market, which will greatly increase accessibility. In addition, medical groups are now approaching the two network model HMOs for affiliations. This is a relatively recent development, which reflects changing physician attitudes.

For the fifteen HMOs that we studied, hospital services are provided on contract. HMOs in the Twin Cities have been suc-

cessful in negotiating discounts of some form with the majority of the Twin Cities hospitals. In Chicago, hospitals have not been willing to negotiate discounts with HMOs until recently.

I would like to conclude by examining the adaptation of HMOs to the rapidly changing health care markets in these two metropolitan areas. First I would like to discuss the Minneapolis-St. Paul area, where the HMO market can be characterized as "maturing". In 1982, nearly 540,000 people, or 27% of the population, were enrolled in HMOs. Aggregate HMO growth rates in the Twin Cities have declined over the past three years: 34% in 1980; 16% in 1981; and 12% in 1982, for an annual average growth of 20%.

The Twin Cities health insurance market is characterized by a large number of employers offering one or more HMOs to their workers. There is also a high level of penetration within firms offering HMOs. In 1976 and 1977, a large number of firms started offering an HMO. The number of firms offering an HMO for the first time has been declining since then.

HMOs in the Twin Cities are involved in developing and opening new markets for their services. By increasing their geographic accessibility, they are able to market to a new set of employers and employees. HMOs are also marketing to smaller employers and, to some extent, individuals. In recent years, HMOs have displayed increasing interest in the Medicare and Medicaid markets. A successful Medicare capitation demonstration has been underway in the Twin Cities for several years. In addition, two social HMO experiments are currently being conducted in the Twin Cities.

Most HMOs in the Twin Cities are developing new benefits, such as pre-paid dental and vision services. In addition, several HMOs are developing low-option benefit packages, featuring extensive co-payments and limitations. One has introduced a benefit package providing for limited coverage of services obtained from non-participating physicians and hospitals, that is, services obtained outside of the HMO's delivery system.

Two of the largest and most prestigious multi-specialty medical groups in the Twin Cities and their affliated HMOs are in the process of merging. A principal reason cited for the merger was to strengthen their competitive position in the health care market. We are observing HMOs in the Twin Cities diversifying their business by providing consulting and management services to other HMOs. The IPA in the Twin Cities is, among other things, selling administrative and claims processing services to self-insured employers. New competitors are entering the market in the Twin Cities. Several preferred-provider plans are being developed by a variety of sponsors, principally hospitals and physician coalitions. HMOs anticipate that these organizations will provide increased competition.

Now I would like to talk about the HMO market in Chicago, which can best be characterized as "developing" and, more recently, "burgeoning". In Chicago nearly 350,000 people, or 5% of the metropolitan population, were enrolled in an HMO in 1982. Aggregate HMO growth rates over the past three years have remained at relatively high levels: 35% in 1980; 21% in 1981; and 46% in 1982, for an annual average growth rate of 34%.

The Chicago health insurance market is characterized by relatively low HMO penetration. Most Chicago employers early on displayed a lack of knowledge concerning the HMO concept and expressed attitudes ranging from lack of interest to open hostility. This necessitated an HMO marketing thrust aimed at educating employers about the HMO concept. All but one of the Chicago-area HMOs sought federal qualification, for the stated reason that this would provide them with access to employers via the mandate. With qualification came the requirement of providing a relatively rich benefit package and rating on a community-wide basis. This benefit package and rating system resulted in a wide premium differential between HMOs and conventional insurance. Limited geographic accessibility also provided an obstacle for HMOs in marketing to employers and employees.

In the last several years the premium gap between HMOs and conventional insurance has narrowed or crossed. Employers are increasingly receptive to the idea of HMOs as cost-containment mechanisms. In the last three years the geographic accessibility of HMOs in Chicago has greatly expanded.

Currently HMOs in Chicago are experiencing intensive growth. HMOs are rapidly enlisting new employer accounts and increasing penetration in existing accounts. HMO marketing, while always competitive in Chicago, is becoming increasingly competitive in the last few years, with the HMOs attempting to differentiate themselves to employers in a variety of ways. In the last two years, there have been two HMO acquisitions by firms with substantial financial resources for expansion, PruCare and Maxicare. In addition, two new HMOs have entered the Chicago HMO market in the last year: Cooperative Health Plan and SHARE Illinois. Both of these organizations have chosen not to seek federal qualification.

In this period of intensive growth, HMOs in Chicago have expressed concern over the recent trends in employee health benefits. This trend is toward low-option, catastrophic coverage and increased employee cost-sharing. HMOs are concerned over their ability to offer the types of health benefits currently in demand by employers, owing to the constraint of federal qualification. There is also a growing concern that under these conditions HMOs will be susceptible to adverse selection.

In summary, I've provided some information on the factors that affect the introduction and development of HMOs. I have also tried to characterize two HMO markets at different stages in

their development. Finally, I have illustrated how HMOs in these two metropolitan areas are adapting to changing marketing conditions.

Recapitulation: Essential Ingredients for HMO Development

ODIN ANDERSON. What can we conclude about the combination of elements that are necessary for the emergence of HMOs and the concept of competitive options?

1. Obviously the precipitant in both metropolitan areas was the rapid rise in the expenditure for health services. The Twin Cities responded earlier and faster because of their style of defining and solving problems.

2. Clearly an absolutely essential element is the interest and cooperation of the business community, the major source of funding together with the government.

3. Then a sufficiently responsive provider community that sees the need to protect its own turf.

4. Possibly also a relatively large supply of hospital beds and physicians. It was recognized that the system had to be shrunk, particularly hospital beds, and it was.

5. The presence of early models of HMOs which were not necessarily established because of cost-containment but which, as types of organizations, became reference points for the main-stream establishment.

6. The early presence of good administrators who were already trained in the peculiarities of HMO administration. There have been no failures in the Twin Cities. There were faltering starts in Chicago, but the existing HMOs are quite well managed and strong.

Maybe the foregoing elements exhaust the list, at least the major ones. I have been told that Paul Ellwood and his Inter-Study were necessary elements. We cannot, however, have Paul Ellwoods in every metropolitan area, and his influence really goes beyond the Twin Cities. I believe Ellwood hastened the Twin Cities HMO development, but it would have come about anyway. His agency produced some first-rate administrators who permeate the HMOs in the Twin Cities.

All metropolitan areas in the U.S. contain the matrix of elements mentioned for HMO development. Each area will, however, have differences in problem-solving styles and circumstances that change the scope and pace of growth, and each area will reach the level of saturation natural to it. A 20% penetration in Chicago is a greater achievement, I believe, than a 30% penetration in the Twin Cities.

Finally, the term "HMO" has become too diffuse: too many types are under the same generic concept, from staff models, the "pure" model, to preferred provider models. Hence employers and their employees, the main funding sources and markets, might become confused. In the process, however, Americans will become very sophisticated about the different forms of health service delivery options.

The Twin Cities are now in another stage. The rapid growth period is over. System-wide consolidations are taking place. The area is now poised for the next stage. The HMOs are reviewing and revising their internal operations in response to external pressures as they begin to collide with each other and the mainstream insurance agencies. The merger of two of them--St. Louis Park Center and the Nicollet-Eitel Plan--is an obvious sign. Chicago looks as if it may be at the take-off stage analogous to that of the Twin Cities ten years ago.

ELI GINZBERG. Let me ask you a question. New York is a desert when it comes to HMOs. You didn't mention anything about capital needed for easy access, the style of capital being a major issue in the development of HMOs. With everything that I've ever been exposed to, that seems to be one of the great big problem areas. And that's why the entrance of commercial insurance companies, and Kaiser, as it expands, seems to be one of the major dynamic elements. What's the capital story in Minneapolis?

MR. HEROLD. Well, initial capitalization for the majority of the HMOs in both the Minneapolis-St. Paul and Chicago areas was by their sponsors. I think more interesting is the recent capitalization of some of the plans in the Chicago area. There have been several very innovative means of capitalizing in recent years, most notably through public offering of stock (Cooperative Health Plan) and tax-exempt bonds (Michael Reese Health Plan). One of the directors of a new HMO here in Chicago, Cooperative Health Plan, is in the audience here, and they have launched on capitalization, as I understand, by selling shares, as well as by physicians contributing participation fees. Maybe Frank Tsai could mention some more about that.

MR. ANDERSON. Why don't you tell about the early attempt of a big insurance company to have a city-wide HMO in Minneapolis-St. Paul?

MR. HEROLD. Yes, that was one aspect of the Twin Cities Health Care Development Project, which was partially sponsored and actively led by the medical director of the Equitable in New York (Leon Warshaw, M.D.). Essentially, one idea of the Equitable was to form an umbrella HMO in the Twin Cities which would provide management and marketing services to the smaller, developing plans. Essentially this was the idea; but it did not receive much favor in the employer community, so it didn't come to fruition.

MR. ANDERSON. Well, if I'm right, Terry, I also got the impression that the Twin Cities area wanted to develop these HMOs from the inside, as grass-roots developments, with groups inside, and not have outside interlopers, as it were, from their standpoint.

GEORGE BUGBEE. Odin, maybe this is too complicated a question to ask, but one of you mentioned catastrophic coverage. How does an HMO fit in to that, either the usual nature of medical or catastrophic coverage?

MR. BUTLER. Well, what we are seeing now is that several of the HMOs are beginning to look at the possibility of competing with the fee-for-service plans by offering their own low-option plans that have high deductibles, and this type of thing. They're hoping to do that in order to avoid running into problems of having high premium differentials with the fee-for-service plans as new cost-containment initiatives are growing.

MEMBER. It's noteworthy that neither city has been impacted yet by Kaiser, and since Kaiser is such a large provider of prepaid health care in this country and has been extending eastward and nationwide, I wonder if you see any possibilities for the development of Kaiser plans and care to speculate on what this might mean for the very small-modelled HMOs that now exist in these towns.

MR. ANDERSON. You mean if Kaiser moves in to areas like that? Well, I'm hardly the one to speak for Kaiser, but my impression is that Kaiser is not interested really in swallowing up a market; they prefer to have a divided market, and would not deliberately, like a big chain store, force out the--well, call it mom and pop and maybe extended family--grandparents. Can you speak to that? You raised your hand.

BERNARD NELSON. I'm Bernie Nelson; I'm with the Kaiser Family Foundation. I recently made a grant to Kaiser for their expansion, although we are not part of Kaiser Health Plan itself. Historically the Kaiser system was reluctant to expand. Its reluctance came almost exclusively from the physicians. As you know, the plans started on the west coast--Portland, San Francisco, Los Angeles-San Diego area--and any expansion at that time was a traumatic experience for those physicians themselves. There was expansion into Hawaii, Denver, Texas, and Washington, D.C., most recently. About a year ago the plan decided that they were going to expand, and they are now planning and working at growth opportunities and areas around the country in which to expand.

What Odin said is absolutely true. As well as reluctance on the part of the physicians to expand, which has now been changed, there was a reluctance on the part of Kaiser to be the only act in town. And there is great concern that if the only successful

HMO was a Kaiser HMO, it would be targetable by pre-paid health care plans, because it does require a lot of capital. It serves as a model, and many people felt it did not fit in and was not acceptable in the communities in which they lived.

If I can just add a footnote to that, and the footnote is in response to Eli Ginzberg's question: One should recognize that an awful lot of the growth in HMOs, the small HMOs, was funded by the federal government through grants and loans from the office of HMO, and when that began to dry up about a year ago--we've been monitoring the development of new HMOs, and I can tell you (I can't recall the numbers accurately, so don't write it down) that something on the order of 250 HMOs that were in some phase of start-up and development over the last few years are now getting going. Despite that fact, you have this tremendous shrinkage of HMOs within the development stage.

The evidence is that there's a lot of HMO activity right now; it's simply that they're going to be following a different pathway than requesting federal support, federal qualification. And they are finding access to capital, although that is a tremendous problem. For a Kaiser-like plan that wishes to achieve a break-even group practice, pre-paid health plan, the 40,000 members provide the kind of economies of scale you need to make it. When you joined the Foundation that was a five- to six-million-dollar expenditure; now you're talking about the early losses and up-front capital somewhere in the twenty-million-dollar range. And this is the kind of capitalization that you have to begin to look for.

Now, on the other hand, what we see as the greatest movers and shakers in many instances, in the west coast, Minneapolis-St. Paul, and other areas, are the existing groups that are going into some kind of pre-payment program, such as the St. Louis Park Medical Center. The capital costs there are not very large. And they have a great advantage, which is the fact that they're already practicing medicine; they are an efficient arranger of hospitalization, and can rapidly develop a workable plan that is very, very competitive. The St. Louis Park Medical Group and the Mayo Clinic have statistics from before and after their involvement in developing a group practice, pre-payment plan, which is no different from the Kaiser and other plans.

REACTOR PANEL, Friday morning, May 20, 1983

RON ANDERSEN. We might start first by asking each of these speakers, now reactors, for reactions they have to the last presentation or indeed the conference as a whole. Eli?

ELI GINZBERG. Well, I heard that HMO study, and I'm impressed that we're now in the ball-park again, and that it is very dangerous to project the first forty years of HMO experience, because if we're going to be in a new situation in which HMOs are going to have to compete with fee for service and offer all kinds of different packages, with co-payments, and if there's the danger of adverse selection going against the HMO, that's a whole new ballpark from anything that I know about in terms of the old structure. So what we really have is something that is carried over semantically but which now represents a whole new range of types and forms.

The last comment that Nelson made was, I thought, very illuminating, 'cause you've got a whole conversion system from group practice to HMOs. And I think that it'll be very important, especially for analysts, to be careful about what they're describing, what the constituent elements are, how that market is really changing and turning around. I think it's a reinforcement of what I said last night, which was that the next decade will see just unbelievable churning in the health care market, and it's really impossible to foresee at this time how it's going to shape up for somewhat more quiet growth in the 'nineties and beyond.

FRANK NICHOLSON. You know, over the years, we HMO folks in Chicago have been asked so many times why is it that in Minneapolis-St. Paul they have thirty percent of the market whereas the lousy marketers in Chicago have only been able to capture three or four percent. And I think the study has shown graphically that there are very major differences between the two communities. In the Chicago metropolitan area there has been massive change over the last couple of years; in fact, if you took the handout of the membership of each of the HMOs in Minneapolis and Chicago--can't talk for Minneapolis, but here in Chicago, for the numbers that are shown on that sheet you can add at least fifty percent to all of them. That's the kind of growth there's been recently. And it's for all of the reasons that have been given.

But despite all of the change in the last couple of years, that change is going to intensify and it's going to change again. And you've heard many comments this morning about the whole issue of risk selection and Professor Ginzberg has just commented on it again. In the Chicago market, more and more employers are changing the benefit structure. They're putting in comprehensive major medical programs, putting in front-end deductibles and co-payments, or freezing the contribution they're making to the employee health care benefit program at the present level and

passing on the excess to the employees. It's become very much of an economic game. It's becoming more of an economic game every day, and everybody's getting more and more sophisticated. That means the employers are getting more and more sophisticated; it means the other decision-makers, the employees, have to decide whether to stay with the traditional program and move into an HMO or switch between HMOs or switch back from the HMO to a traditional program.

Looking at it very much from the standpoint of the economics of it, we are seeing significant changes in our utilization patterns, and I personally question whether HMOs have really ever creamed off the best risk, as many people have said. Yes, it's very attractive to the younger people. But it's also very attractive to the people who have chronic conditions, who are high utilizers. And there's a tremendous imbalance between the costs of a few of those people and the costs of the healthy people. You've got to get them back in balance. So we're seeing more and more change taking place. And that's going to continue and intensify. And we in the HMO movement, as well as everybody else, are going to adjust and adapt to that change.

Now, I'm personally convinced that the key to it is how the physicians are reimbursed, primarily; that's the key to it. Whether you call it "HMO"--and I agree with one of the comments that was made; the name "HMOs" is getting misleading, 'cause there are all kinds of different types--or whether you call it "PPO", or whatever you call it, the reimbursement mechanism away from the disincentives of fee for service, whereby the physicians, who make the decisions in our industry in the main, are on risk and have some kind of incentive program to go with the risk: that is going to be the wave of the future. You've got to address, obviously, the issue of benefit differentials, price differentials, and all of those other things. But the key to the future, so that the costs of health care in the country are within reasonable bounds, and where quality of care is maintained, whatever the word "quality" means--and you're seeing more and more in that direction: Medicare is doing it; Medicaid is doing it; they're trying to get a Medicaid program, a capitated Medicaid program, off the ground here in Illinois--there's more and more move toward risk-sharing and incentive for the physicians and away from fee for service. And I think that is going to accelerate. The whole industry, the change that's taking place: we ain't seen nothin' yet. We've got a long way to go; there's going to be more and more change. And it's a very exciting industry to be in as a result of it, but also very challenging.

MR. (ODIN) ANDERSON. When you say change from fee for service, you mean the capitation. They can still be paid fee-for-service.

MR. NICHOLSON. I think, yes, primarily a capitation but also--that's the risk. And you can't just have capitation. You

can't just have risk. You've also got to have some incentive built in. Now most of the incentives presently are based on hospitalization: Whether it's cost of hospitalization or days of hospitalization, most of the structures are built in that manner. But I think you're going to find that there are going to be incentives built in on the ambulatory side, maybe more than there have been up to now. Yes, I suppose it can be fee for service; I just personally believe that fee for service is a disincentive to do some of the things, to do maybe all of the things, that need to be done. So forms of fee-for-service, yes, maybe, but I don't think they're as effective as an arrangement whereby there is risk and incentive and no tie-in or tie-back fee-for-service at all.

MR. (RON) ANDERSEN. Dan, yesterday you discussed your concerns about access and quality in the face of efforts to move towards cost-containment. What are your reflections about the impacts of HMOs on these issues?

DANIEL WIKLER. I think I'd rather speak more broadly to the whole complex of new developments that have been spoken about in the last couple of days. This conference has certainly impressed on me even more strongly than before how much of a revolution the health system is going through right now, with people taking up new roles, finding new allies and new enemies, from what had occurred in the past. As I sat here yesterday, and heard Mr. Goldbeck talk about the attitudes of his business clients with respect to physicians, I had to shake my head several times and try to realize that this was not a 'sixties Naderite radical speaking.

A few years ago, some of you will remember, a Nader group circulated a questionnaire to some hospitals and physicians in, I think, the Maryland suburbs of Washington, D.C., asking about prices, some basic information that consumers might use. And the story is--I believe it's true--that the state medical society sent a memo to every one of its members saying that anyone who filled out that questionnaire would be drummed out immediately. And that was taken by the health radicals of the area as proof that the medical profession was again conspiring to deprive consumers of adequate information so that they could chart their own medical destinies. Well, now I'm hearing the same kind of vehement indignation coming from someone who says that he's working on behalf of businessmen. And since these Naderite health radicals usually weren't the allies of the businessmen, transitivity fails here; it's hard to figure out who's on whose side. And I suspect that that's going to turn out to be more and more true.

Another paradox that came out in the first talk yesterday was that the cost-shifting that goes on amounts in part to making the employers who pay the private insurers subsidize the cost of providing medical care for the poor. And the more that subsidy is choked off by accounting procedures that make it more diffi-

cult to do so, the more the continued care for the indigents is imperilled. And so here we find again very strange bedfellows, where it's the big corporations, big capital, and so on who are in effect setting up (although with enormous protest) their own little welfare programs.

So as I hear of these enormous changes in the structure, of different allies and so on, it makes me realize that the old certainties are gone, that one doesn't know who one's friends are and who the enemies are. And it makes me wonder, most specifically, about whom it is that we can count on to consider themselves responsible for the plight of the poorest; and I think that Dr. Ginzberg referred to this last night, in answer to a question. In all of this shuffle (and it's a tremendous shuffle), there are going to be some people, those who are at the bottom--especially those who are not covered by one of the entitlement programs, and that still is at least half the poor--who apparently don't have any natural allies and who might very well get lost in all of this; and it seems to me that unless we're paying very, very close attention to the plight of these poorest and tracking their fate, in fact, they might get lost without a blip in our consciousness.

MARVIN BERZ. I'm Marvin Berz of the Executive Corps of Chicago HMO Project, and your remark about strange bedfellows reminds me of what happened when we were asked by the Illinois Association of HMOs to help them with their marketing and promotion plans, and a good many of our membership, which comprises former chief executives and corporate board chairmen of the leading corporations in town, thought this was a wild-eyed radical scheme. But this entire [symposium] program reminds me of Odin inviting us a few months back to his conference over at MIT. Sapolsky, who has written an article (out of date, I thought, in terms of his data) said that business didn't care. Well, business sure as hell does care at the present time what Will Goldbeck of Washington was doing, and what Jim Mortimer was doing in Chicago with his business group certainly attests to the fact that business really does care.

Then, too, I just came back from the National Urban Council in Washington, and there the heavy, heavy emphasis is on private involvement in the educational industry not only on the part of the corporate community but also in terms of the capital that Eli asked about. It is forthcoming from Connecticut General and INA, who have combined to form CIGNA, and they're deep in this. Equitable is thinking about getting back into that campaign; PruCare was around; Hospital Corporation of America; Health Plans of Nashville--it sounded as if somebody was touting the stock market possibility of HMOs. Len Abrams of the Philadelphia, Pennsylvania Health Plan said the stock gives you twenty to fifty-five in short order; Maxicare, Fremont General's parent, have put out a stock issue that's going wild. So the whole emphasis these days is away from government grants, government loans, and the involvement of the private sector.

I think that another area that some of the HMOs are taking advantage of, and certainly more will, is an old Medicaid, Medicare area. Here in Illinois, as some of you know, we have requests for proposals for combining inpatient and outpatient on a prospective basis. Medicare is now coming up with a formula for the reimbursement of 95% of usual and customary days, which should make it more attractive for HMOs to get into that area. I think we're sitting on the tip of a volcano right here in Chicago.

MR. (ODIN) ANDERSON. Well, that sounds like we'll be blown apart!

MR. GINZBERG. I think we've now begun to put onto the table some of the sub-elements that have to be looked at very carefully to get any feeling of where this system's going. Let me try a few comments on the extent of the pressures and counter-pressures. The first thing is that there's going to be a lot of competition within key elements; that is, it'll be established physicians against the youngsters who are coming in. That's going to be a very rough fight, because those youngsters are going to have increasing difficulty getting established and making a living. So there's going to be for the first time a whole new set of forces within the medical profession between those who have it--and this'll show up very clearly in terms of admissions to hospital staffs; I think most hospital administrators will spend most of their lives shortly in the courts, explaining why they've been trying to close the staffs at the best of the established physicians while the new ones want to get in. That's one thing.

Second, I see--and we didn't bring to the surface very much about this yet--what I would call the "cross-competition" between physicians and hospitals. I expect physicians to proceed with the unbundling of valuable ancillary services just as fast as they can, to take 'em out of the hospital in order to have a larger part of money for themselves, and, in turn, the hospitals going into the primary-care market or any other kind of market to tie up patients, because without those patients they're not going to keep their beds filled. So that's a whole new story, quite different from anything that we've lived through recently.

Third, I think it's worthwhile to note that the Senate voted last night to pass a special medical care, hospital care, provision for the unemployed. So we're going to have a fight within the government constraining doctors between what I would call the poor or the totally uncovered, and eventually the middle-class people who are covered by Medicare, more generally. That's going to be another kind of fight, because those dollars are not going to be able to cover everybody, and I've been impressed under the Reagan second and third budgets that he has been unable to convince the Congress to go back on Medicaid any further. I don't know what the states are doing, but the federal govern-

ment--at least the Congress--has said, "No, enough's enough; these are the poorest people; we're going to keep them covered." And yesterday's action, I think, is interesting in this regard.

Now business hasn't, I think, yet fully understood the counter-pressures that it's under. It's understood the fact that it has to become more active and try to save some of its dollars, or put a ceiling on those dollars, or do something. But I want to wait and see how some of these business-people begin to react when the only hospital in the community in which they have a plan starts to go under. They've got a lot of counter-pressures on them, and I don't think we're in that ballpark yet because that's still to come.

See, at this moment everybody thinks this is a great big game that everybody's going to make money from. I don't believe a word of it. I don't really think that HMOs--let's say, financed by private-sector interests--are a winning game at all. I've talked to INA quite a lot; I've talked to Metropolitan, Equitable, Prudential. I keep warning them. I think they're mad. I think at this moment in time they still have found segments and special areas--Dallas, Tampa, and so on--where they can make a buck out of this. But I don't think this is a buck-making world, and from what I heard this morning I think it'll be less so down the line. You may be able to handle HMOs in some kind of a cooperative, small-venture system and so on. So, in any case, I've just tried to lay out before you what I believe to be just a whole series of question marks for myself, the outcome of which is highly problematic. Every piece of this is highly problematic now.

ALFONSO D. HOLLIDAY. I have not heard anyone discuss the impact of the DRG on the HMO. How will it affect the competitiveness, profitability, and attractiveness to the private investor as they're going onto the stock market? Will they have to unbundle and somehow reduce their ambulatory costs to be competitive, since they're going to lose their edge on the hospital section because everyone's going to have to come into the same ballgame with the DRG?

MR. (ODIN) ANDERSON. Well, we've lost our DRG experts but those chickens of us remaining, I guess, can try to comment. Does anyone have feelings about this?

RESPONSE. I just think that that question depends very much on what type of HMO you're talking about. Clearly it's going to be of most concern to the IPA and of least concern to the group practice HMOs, although the evidence suggests that the HMOs hospitalize with about the same intensity as fee-for-service practice. And to the extent that that's true, you would not think that they have a problem. However, yesterday I was talking to a medic. He said that HMOs in New Jersey and elsewhere are complaining bitterly; they feel that the DRGs in those states are going to have a detrimental effect on them, which suggests that

they think at this point in time that they must be hospitalizing at different rates and behaving somewhat differently than a fee-for-service physician. All of this illustrates the fact that they have a really major problem which comes up when you talk about this. There is very, very little good data about physician behavior associated with HMOs in terms of rates of hospitalization. And so an awful lot of this, I'm sure, is speculation on their part.

RESPONSE. I'm not sure that it's politically feasible, but logically it seems to me there are two steps that would follow from the DRG approach. One is to cap all hospital care per person per time period, and the next logical step is to cap other kinds of services as well, per person per time period, which sounds very close to the HMO concept.

MR. (ODIN) ANDERSON. In listening to what Joel May and Howard Berman and Frank Sloan said, what I was struck by was that none of them expected that what is taking place, what is being codified, DRGs, etc., etc., reimbursement, will ever reach its logical conclusion. And this is why everything is problematic, because there are are lots of interests and lots of politicians in the game.

You know, the major infrastructure of the health services, not just here but everywhere, is a very tenacious or conservative institution, so that we will not willy-nilly let a hospital go under just because of some technical matter regarding a DRG. Maybe only the worst ones, according to anybody's definition, will go, so that we're getting an overall systems balancing here, which as Eli was saying is very hard to predict what it will look like a few years from now. So I guess I'm pretty much of an optimist, although I work like a pessimist. No, no, it's the other way; it's the other way. I'm a pessimist and work like an optimist--as long as the interests are working more or less in good faith and are not going to reach for the jugular and shoot each other, you know, and will permit at least a modicum of survival--or at least buy them off--give them severance pay or something, metaphorically speaking. So those of you who are now much younger than I am and are in the midstream, if you cannot bear this kind of seeming chaos you'd better try to arrange as soon as possible with your board for early retirement. Or go to Minneapolis.

MR. (RON) ANDERSEN. Any other comments or questions from the floor? Any final reactions from the panel? I'd like to thank you all for attending this symposium; special thanks to our speakers. And I'll look forward to seeing all of you next year, which will be our twenty-sixth symposium and also the fiftieth anniversary of the program in hospital administration, and we plan a special program related to that event. Thank you.

REGISTRANTS

Lu Ann Aday
Associate Director for Research
Center for Health Adm. Studies
5720 S. Woodlawn
Chicago, IL 60637

Ronald Andersen
Director
Grad. Prog. in Hosp. Adm. and
Ctr. for Hlth. Adm. Studies
University of Chicago
1101 E. 58th St.
Chicago, IL 60637

Glenn L. Anderson
President
Mercy Hospital
2601 Electric Avenue
Port Huron, MI 48060

Odin W. Anderson
Professor Emeritus of Sociology
Grad. Prog. in Hosp. Adm.
University of Chicago
1101 E. 58th St.
Chicago, IL 60637

Richard O. Baer
Assistant Director
Univ. of Chicago Med. Ctr.
950 E. 59th St.
Chicago, IL 60637

Richard A. Batt
Vice President-Operations
Ancilla Domini Hlth. Svcs., Inc.
1100 Elmhurst Rd.
Elk Grove Village, IL 60004

Ned Becker
Research Associate
American Medical Association
535 N. Dearborn
Chicago, IL 60610

Fred Benjamin
Asst. Vice President-Strategic
Planning
Grant Hospital of Chicago
550 W. Webster
Chicago, IL 60614

Weston Bergman, Jr.
Associate Director
Grady Memorial Hospital
80 Butler St., S.E.
Atlanta, GA 30335

Howard Berman
Group Vice President
American Hospital Association
840 N. Lake Shore Dr.
Chicago, IL 60611

William L. Boyd
Vice President-Adm. Svcs.
Memorial Medical Center
800 N. Rutledge St.
Springfield, IL 62781

George Bugbee
VA Lakeside Hospital
333 E. Huron St.
Chicago, IL 60611

Michael E. Burack
President
Multi Risk Management Inc.
180 N. LaSalle St.
Chicago, IL 60601

Bradley Burfield
Research Associate
American Medical Association
535 N. Dearborn
Chicago, IL 60610

Stuart S. Burstein, M.D.
25 E. Washington St.
Suite 1733
Chicago, IL 60602

Bruce Butler
HMO Project
Center for Health Adm. Studies
1101 E. 58th St.
Chicago, IL 60637

Bruce Campbell
Executive Director
Univ. of Chicago Med. Ctr.
950 E. 59th St.
Chicago, IL 60637

Brian Channon
Director, Performance Enhancement
HealthWest Foundation
20500 Nordhoff St.
Chatsworth, CA 91311

Jim Clarke
Prof. Services Rep.
Cooperative Health Plan
65 E. So. Water St.
Chicago, IL 60601

Howard Cook
President
Chicago Hospital Council
840 N. Lake Shore Dr.
Chicago, IL 60611

Harvey Dershin
Sr. Vice President-Prof. Svcs.
Grant Hospital of Chicago
550 W. Webster
Chicago, IL 60614

Robert A. DeVries
Program Director
W.K. Kellogg Foundation
400 North Avenue
Battle Creek, MI 49016

Robert Emerman
Vice President
Brigham and Women's Hospital
75 Francis St.
Boston, MA 02115

Roger N. Ervin
Assistant Treasurer
ServiceMaster Industries Inc.
2300 Warrenville Rd.
Downers Grove, IL 60515

Gretchen V. Fleming
Sr. Research Associate
Center for Health Adm. Studies
5720 S. Woodlawn
Chicago, IL 60637

Richard Foster
Associate Director
Grad. Prog. in Hosp. Adm.
University of Chicago
1101 E. 58th St.
Chicago, IL 60637

Mark R. Gavens
Assistant Vice President
St. Joseph's Hospital
5000 W. Chambers St.
Milwaukee, WI 53210

Eli Ginzberg, Ph.D.
Director, Conservation of Human
Resources
Columbia University
New York, NY 10027

John A. Gjertson
Director-Western Reg. Office
Illinois Hospital Association
1200 Jorie Blvd.
Oak Brook, IL 60521

Thomas Goldenbogen
Mercy Hospital
2601 Electric Ave.
Port Huron, MI 48060

Jim Green
Med. Svcs. Rep.
Cooperative Health Plan
65 E. So. Water St.
Chicago, IL 60601

Phillip J. Haas
Vice President
Illinois Hospital Association
1151 E. Warrenville Rd.
Naperville, IL 60566

Alex Harmon
1828 Keys Crescent
Cincinnati, OH 45206

Arthur J. Henkel
Vice Pres. & Managing Officer
Kidder, Peabody, & Co., Inc.
10 Hanover Square
New York, NY 10005

Terry Herold
HMO Project
Center for Health Adm. Studies
1101 E. 58th St.
Chicago, IL 60637

Alfonso D. Holliday, M.D.
President
Holliday Health Care, P.C.
8410 Maple Ave.
Gary, IN 46403

Mary L. Hopkins
Sr. Benefits Analyst
Baxter Travenol Laboratories, Inc.
One Baxter Parkway
Deerfield, IL 60015

Kermit "Skip" Housh
Director
HMO Illinois
233 N. Michigan Ave., Suite 1625
Chicago, IL 60621

Edward F.X. Hughes
Professor and Director
Program in Hlth. & Hosp. Svcs. Mgmt.
Northwestern University
2001 Sheridan Rd.
Evanston, IL 60201

Jan Huttner
Clinical Skills Coordinator
Dept. of Medicine
Univ. of Chicago Med. Ctr.
950 E. 59th St.
Chicago, IL 60637

John C. Imhoff
President
Galion Community Hospital
Portland Way South
Galion, OH 44833

Richard L. Johnson
President
TriBrook Group, Inc.
1100 Jorie Blvd.
Oak Brook, IL 60521

John W. Kaminski, M.D.
Corporate Director, Medical Svcs.
Zenith Radio Corporation
1900 N. Austin Blvd.
Chicago, IL 60639

Marion Kessler
Chicago Community Trust
208 S. LaSalle St.
Suite 850
Chicago, IL 60604

Donald West King
Dean, Biological Sciences
Pritzker School of Med.
University of Chicago
950 E. 59th St.
Chicago, IL 60637

Claire Kohrman
HMO Project
Center for Health Adm. Studies
1101 E. 58th St.
Chicago, IL 60637

Andrew Korsak
Health Insurance Assoc. of America
332 S. Michigan Ave.
Chicago, IL 60604

Larry Lewin
President
Lewin & Associates, Inc.
1090 Vermont Ave., N.W. Suite 700
Washington, DC 20005

Joseph Liberatore
Consultant
Blue Cross/Blue Shield Assoc.
676 St. Clair
Chicago, IL 60611

Christine L. Malcolm
Manager
Coopers & Lybrand
222 S. Riverside Plaza
Chicago, IL 60606

Harry A. Malone
Personnel Officer
Continental Illinois Nat'l. Bank
231 S. LaSalle St., Rm. 1645
Chicago, IL 60693

John R. Mannix
Consultant
1021 Euclid Ave., Rm. 200
Cleveland, OH 44115

Ronald M. Mattei
Senior Vice President
Mercy Hospital
2601 Electric Ave.
Port Huron, MI 48060

J. Joel May
President
Health Res. & Educ. Trust of NJ
760 Alexander Rd., CN-1
Princeton, NJ 08540

John H. Mitchell, M.D.
Assistant Medical Director
Standard Oil Company (Indiana)
200 E. Randolph Dr.
Chicago, IL 60602

Ellen Morrison
HMO Project
Center for Hlth. Adm. Studies
1101 E. 58th St.
Chicago, IL 60637

Reed Morton
Associate Director
Grad. Prog. in Hosp. Adm.
University of Chicago
1101 E. 58th St.
Chicago, IL 60637

Bernard Nelson, M.D.
Executive Vice President
Henry J. Kaiser Family Fdn.
525 Middlefield Rd., Ste. 200
Menlo Park, CA 94025

John Newman
Director, Res. & Develop.
Blue Cross & Blue Shield Assoc.
676 N. St. Clair
Chicago, IL 60611

Frank E.E. Nicholson
Vice Pres., Hlth. Svcs. Dept.
Illinois Blue Cross/Blue Shield
233 N. Michigan Ave., Ste. 1625
Chicago, IL 60601

Donald R. Oder
Sr. Vice President
Rush-Pres.-St. Luke's Med. Ctr.
1725 W. Harrison St., Rm. 1188
Chicago, IL 60612

Sharon Oxendale
Asst. Director, Planning
Lutheran General Hospital
1775 Dempster
Park Ridge, IL 60068

Andrew Pattullo
162 Feld Dr.
Battle Creek, MI 49017

Kathleen H. Pedziwiatr
Associate Director
MacNeal Memorial Hospital
3249 S. Oak Park Ave.
Berwyn, IL 60402

J. Robert Pellar
Director
Coopers & Lybrand
222 S. Riverside Plaza
Chicago, IL 60606

Theresa Pestrak
Pritzker Sch. of Med.
Univ. of Chicago Med. Ctr.
950 E. 59th St.
Chicago, IL 60637

J. Philip Peterson
Assistant Administrator
Swedish Covenant Hospital
5145 N. California
Chicago, IL 60625

Richard Polheber
Vice President-Operations
Tucson Medical Center
P.O. Box 42195
Tucson, AZ 85733

Laura B. Reale
Director of Planning
CIGNA, Corporation
Hartford, CT 06152

Reed Reynolds
Asst. Professor
Purdue University
Hammond, IN

Larry A. Rice
Human Res. Info. Specialist
Univ. of Chicago Med. Ctr.
950 E. 59th St.
Chicago, IL 60637

Glenn Richards
Field Editor
American Hospital Publishing, Inc.
211 E. Chicago Ave.
Chicago, IL

Leonard Robins
Associate Professor
Public Adm. Program
Roosevelt University
Chicago, IL

Aija Ronis
Specialist, Compensation &
Benefits Dept.
Honeywell Corporation
600 Second St., N.E.
Hopkins, MN 55343

Alan Rosenberg, M.D.
Associate Med. Director
Michael Reese Health Plan
3055 S. Cottage Grove Ave.
Chicago, IL 60616

Douglas O. Rosenberg
Executive Vice President
The Glenbrook Hospital
2100 Pfingsten Rd.
Glenview, IL 60025

Richard Ross
Board Member
Grant Hospital of Chicago
550 W. Webster
Chicago, IL 60614

John Schneider, M.D.
Assoc. Prof. of Medicine
Univ. of Chicago Med. Ctr.
950 E. 59th St.
Chicago, IL 60637

Jody Sindelar
Associate Professor
Grad. Sch. of Business
University of Chicago
1101 E. 58th St.
Chicago, IL 60637

Tim Size
Executive Director
Rural Wisconsin Hosp. Cooperative
P.O. Box 7
Sauk City, WI 53583

Ellen Slezak
Teach 'em, Inc.
160 E. Illinois St.
Chicago, IL 60611

Frank Sloan
Professor, Dept. of Economics
Vanderbilt University
Box 1503, Station B
Nashville, TN 37235

Charles T. Sweeny
Vice President-Facilities Planning
Mount Zion Hosp. & Med. Ctr.
San Francisco, CA 94120

Frank Tsai
Executive Director
Cooperative Health Plan
65 E. So. Water St.
Chicago, IL 60601

Kenneth R. Whittemore
Division Chair
Health Services Adm.
Governors State University
Park Forest South, IL 60466

Daniel Wikler
Associate Professor
University of Wisconsin
1300 University Ave.
Madison, WI 53706

Annual George Bugbee Symposium on Hospital Affairs

(Currently available titles are listed below. Out of print titles are available in photocopied form at the prices indicated.)

HA 5 *Where is Hospital Use Headed?* Proceedings of the Fifth Annual Symposium on Hospital Affairs, 1962. $3.50.

HA 6 *The Impact of Changing Medical Practice on Hospital Administration*, Proceedings of the Sixth Annual Symposium on Hospital Affairs, 1963. $3.50.

HA 7 *Can Voluntary Controls Do the Job?* Proceedings of the Seventh Annual Symposium on Hospital Affairs, 1964. $3.50.

HA 8 *Applications of Studies in Health Administration*, Proceedings of the Eighth Annual Symposium on Hospital Affairs, 1965. $3.50.

HA 9 *Hospital Size and Efficiency*, Proceedings of the Ninth Annual Symposium on Hospital Affairs, 1966. (Photocopy only) $4.70.

HA 10 *Medical Care for Low Income Families*, Proceedings of the Tenth Annual Symposium on Hospital Affairs, 1967. (Published as Volume 5, No. 1 of *Inquiry*, March 1968.) $3.50.

HA 11 *Physician Productivity and the Hospital*, Proceedings of the Eleventh Annual Symposium on Hospital Affairs. (Photocopy only of selections published in Vol. 6, No. 3 of *Inquiry*, 1969.) $2.30.

HA 12 *Urban Community Hospital in Transition*, Proceedings of the Twelfth Annual Symposium on Hospital Affairs, 1970. $3.50.

HA 13 *Health Maintenance Organizations: A Reconfiguration of the Health Services System*, Proceedings of the Thirteenth Annual Symposium on Hospital Affairs, 1971. $5.50.

HA 14 *Public Control and Hospital Operations*, Proceedings of the Fourteenth Annual Symposium on Hospital Affairs, 1972. $5.00.

HA 15 *The Hospital's Role in Assessing the Quality of Medical Care*, Proceedings of the Fifteenth Annual Symposium on Hospital Affairs, 1973. $6.50.

HA 16 *Government Involvement in Health Services Delivery: The Canadian Experience*, Proceedings of the Sixteenth Annual Symposium on Hospital Affairs, 1974. $7.00.

HA 17 *Ethical Issues in Health Care Management*, Proceedings of the Seventeenth Annual Symposium on Hospital Affairs, 1975. $8.50.

HA 18 *Survival in Utopia (Growth Without Expansion)*, Proceedings of the Eighteenth Annual Symposium on Hospital Affairs, 1976. $8.50.

HA 19 *Organization for Ambulatory Care: A Critical Appraisal*, Proceedings of the Nineteenth Annual Symposium on Hospital Affairs, 1977. $8.50.

HA 20 *Creative Retrenchment*, Proceedings of the Twentieth Annual Symposium on Hospital Affairs, 1978. $8.50.

HA 21 *Changing the Behavior of the Physician: A Management Perspective*, Proceedings of the Twenty-First Annual Symposium on Hospital Affairs, 1979. $8.50.

HA 22 *Managing for Growth and Future Expansion*, Proceedings of the Twenty-Second Annual George Bugbee Symposium on Hospital Affairs, 1980. $8.50.

HA 23 *Competition-Regulation and the HMO; Impact on Hospitals and Physicians*, Proceedings of the Twenty-Third Annual George Bugbee Symposium on Hospital Affairs, 1981. $8.50.

HA 24 *Multi-Hospital Systems and the General Hospital*, Proceedings of the Twenty-Fourth Annual George Bugbee Symposium on Hospital Affairs, 1982. $8.50.