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STATEMENT

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COST CONTAINMENT STRATEGIES AND THE TEACHING HOSPITAL

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by

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Cost Containment Strategies and the Teaching Hospital

The Association of American Medical Colleges represents all 127 medical schools, 76 academic societies, and, through its Council of Teaching Hospitals (COTH), 430 teaching hospitals. There are five issues I wish to discuss briefly this afternoon: uncompensated care, graduate medical education, diagnostic case mix, regional standby services and the presence of clinical research. Each of these five issues deserves your special attention as the philosophy underlying the direction of providing hospital and physician services moves in conflicting directions across the country. In some parts of the country, hospitals and physicians are adapting to a more traditional, commercial marketplace. In Maryland and in Massachusetts, New Jersey and New York we are learning to function in a regulated marketplace. In both the marketplace and regulated models, hospitals are beginning to compete for patients on a price basis. I shall return to this point later in my testimony.

I shall begin by making some observations about the subject of uncompensated care. Beginning in the mid-sixties with major impetus from the Medicare and Medicaid programs, this nation undertook a major effort to bring all its citizens into the mainstream of American medicine and hospitals. Substantial efforts have been made to eliminate two class systems of medical care and to move away from the concept of charity care hospitals. While much remains to be done, substantial progress has been made. However, the burden of providing ucompensated care is very unevenly distributed. In 1980, non-Federal COTH members, which comprise 6% of the nation's community hospitals and 18% of the admissions, incurred 35% of the bad debts and provided 47% of the charity care. Even within this group of COTH members, the burden is not equitably distributed.

Some COTH members, both publicly owned and not-for-profit, provide vast amounts of uncompensated care while others provide an amount comparable to non-teaching, non-profit hospitals.

At the outset, several observations should be made to help ensure a common frame of reference. First, major amounts of uncompensated care are presently being provided by some of the nation's hospitals. The expenses necessary for this care -- staff, supplies, facilities, and equipment -- are already in the present hospital system. While the financing of those services is a "hodge-podge" of cost shifting, philanthropy, lost earnings and appropriations, hospitals currently are able to provide significant amounts of uncompensated care. What is most at risk in the re-structured environments is that the self focused cost containment efforts of individual third party payers will silently squeeze the present level of funding for uncompensated care out of the system. This is related to a second observation: the increases in the price consciousness of buyers of hospital services place hospitals with large uncompensated care burdens at a significant and growing disadvantage. In the absence of a comprehensive entitlement program for financing health services of the poor and medically indigent, hospitals have, where possible, historically set their prices to subsidize uncompensated care with funds from their paying patients. In a marketplace of price sensitive consumers, hospitals which attempt this cost shifting to underwrite uncompensated care will be at a significant disadvantage. Their necessarily higher prices will make them less attractive to paying patients, and, as paying patients choose cheaper hospitals without the uncompensated care "surcharge," the financial problem of the hospital with a major uncompensated care burden will get worse and worse.

The bottom line conclusion of these observations is clear: uncompensated care is a major problem in a competitive environment because uncompensated care is unevenly distributed across hospitals. This uneven distribution in a competitive market handicaps hospitals serving the indigent and medically indigent and benefits hospitals with primarily paying patients. As Princeton Professor Ewe Reinhardt has stated, "to saddle providers of indigent care with the dual responsibility of first, treating uninsured indigents, and second, casting about for a private source that can be forced to pay for such care strikes one as dubious social policy, particularly when the burden of that care is so unevenly distributed among hospitals." Given current trends, and the unevenly distributed burden of providing ucompensated care, it seems clear that if substantial changes are not made, we shall return to the two class system of providing hospital and medical services, and access to services for those who cannot afford to pay for them will be severely curtailed.

"Cost shifting" is a term that is used to describe the circumstances when an individual is provided services, and the cost of doing so is shifted to another payer or other payers since that individual either cannot or will not pay for the services. This term has been used largely to describe this phenomenon as it has occurred in discussions of uncompensated care. However, there are other types of cost shifting that do occur in hospital financial arrangements. They are more commonly referred to as cross subsidies, but the principle is the same. The environmental and direct costs of education, the special standby services, and the distinctive diagnostic case mix of teaching hospital patients are all subsidized for the most part using patient care revenue from routine patients.

Tertiary Hospital Services

The teaching hospital's patient care reputation is clear; it is the place for the most severely ill patients. Teaching hospitals are the primary source of microsurgery, joint replacement surgery, transplant surgery, specialized laboratory and blood banking services, and specialized neurological and ophthalmology procedures. Attachment A rather dramatically demonstrates the volume of special service contributions made by teaching hospitals. Patients with the most severe medical needs tend to be sent to teaching hospitals for the latest patient care capabilities.

In 1980, the 329 non-federal members of COTH performed:

- o 68% of the pediatric open heart surgeries;
- o 49% of the computerized (CT) head scans;
- o 47% of the adult open heart surgeries; and
- o 30% of the computerized (CT) body scans

provided by short-term, non-federal hospitals.

While the charges for many of these services are related to the costs of providing them, there are some services for which special charges are not made, or charges are not set high enough to cover full costs. For example, at the University of Maryland Hospital we provide services to a very substantial number of high risk pregnant women. The cost of providing services to these women is substantially higher than the cost of providing service to a woman whose pregnancy is without substantial risk. In most hospitals, as is the case at the

University of Maryland Hospital, the charges for services to these two groups of women are substantially the same. However, the costs of providing these services are quite different. In effect, the patient with extensive needs is being subsidized by the patient with routine needs since the charges and costs are based on "averages." A number of researchers are presently developing indices to measure severity of illness and intensity of service. If successful, these efforts may improve price comparisons between hospitals and legitimate price differentials within hospitals. These efforts are particularly important to teaching hospitals since the teaching hospital serves more intensively ill patients. Until such research efforts provide a practical way to measure these variations, the "average" cost or charge of teaching hospitals will be higher than the "average" cost or charge for non-teaching hospitals. In a market where patients are sensitive to hospital prices, the teaching hospital is therefore at a disadvantage.

Full Service Clinical Education

Teaching hospitals are major educational institutions. In 1983, COTH short-term, non-federal hospitals provided the training sites for over 45,000 residents and fellows in graduate medical education programs, over 30,000 students in the last two years of medical school, and large numbers of nurses and allied health students. As major teaching hospitals, non-federal COTH members are active participants in multiple residency training programs; 6% of the hospitals participated in at least 26 residency programs; 41% participated in 16 or more programs. At least 70% of the COTH hospitals provided programs in the basic specialties of internal medicine, general surgery, obstetrics-gynecology, pathology, orthopaedic surgery, and pediatrics.

The clinical education of medical, nursing and allied health students is organized around the daily operations of the hospital. Patients are being treated and students are being trained through the same activities. In effect, both products - patient care and education - are being simultaneously, or jointly, produced. The joint nature of patient services and clinical education does not imply that education is being produced without additional costs - education is not simply a byproduct. The addition of the educational role does involve additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. It is most difficult, however, to identify distinctly many of the educational costs because of the impossibility of a clear separation of clinical care from clinical education. It is also difficult to quantify the service benefits teaching hospitals receive from physicians, nurses, and technicians in training programs.

Residents learn clinical skills through supervised participation in the diagnosis and care of patients. The patient service benefits that accompany this learning reduce, in some part, the costs of graduate medical education programs. The cost reduction varies with the patients' clinical needs and the residents' level of training. Service benefits provided by residents are probably more substantial for tertiary care patients requiring continuous medical supervision than for routine patients and are greater for senior residents than junior residents. While there is no conclusive study comparing the costs added by residency programs with the service benefits provided by residents, hospital executives and medical educators generally believe that the costs of operating educational programs exceed the service benefits obtained by patients. This added cost is the investment necessary to adequately prepare the future generation of

professional health personnel; and its inclusion in hospital prices disadvantages teaching hospitals in a price sensitive market.

Clinical Research

In the past four decades, the medical sciences have made dramatic advances in diagnosis and treatment. Much that is now widely available was unknown a generation or two ago. Many of these advances began in the basic research laboratories of universities and their affiliated hospitals; most of the advances were transferred to patient care as clinical research programs at teaching hospitals.

The presence of medical research in the teaching hospital has environmental, managerial, and financial implications. To attract and retain research-oriented faculty physicians, the hospital must create and maintain a climate conducive to research. Research scholarship must be esteemed, research support and supplies must be readily available and individual hospital departments must be flexible and responsive to the demands accompanying research. Managerially, the inclusion of medical research in a teaching hospital's primary mission requires governing board and senior management commitment to integrating research into the daily operations of the hospital. Specialized supporting staff must be hired and trained, necessary research review and patient protection procedures must be developed and monitored, record-keeping and reporting procedures for the funding organization must be established, and management styles appropriate for personalized and efficient patient care must be balanced with collegial style appropriate for research productivity. Without an appropriate environment and management, research will not flourish.

Establishing a medical research program increases a teaching hospital's costs. Additional costs are incurred for staff, supplies and equipment, space maintenance and upkeep, and record keeping. Most, but not all, of these added costs are supported by grants, contracts, endowments, and gifts. Regular hospital services provided for research patients are generally paid by the patient or his third party coverage.

There is much to be said and understood about this subject. However, the point I wish to leave with you is that without an appropriate environment and management attitude, research simply will not flourish.

DISCUSSION

I have taken some time to describe the societal contributions of teaching hospitals. I have done so to be sure certain questions get proper attention. In a broad societal context, the question becomes, "Will certain desirable functions be continued?" Under both regulated and marketplace models, price competition is the present emphasis and teaching hospitals are disadvantaged by the pricing implications of charity care, special services, and education. Whether we move in the direction of competition or regulation, it's easy to say, "Sure, clinical research will move ahead, new tertiary services will be available, manpower will be trained and educated, and someone will take care of the poor." Those words roll out so easily, and more recently, with greater and greater frequency. However, the financing arrangements and characteristics of the hospital environment which have enabled us to support these important societal contributions of the teaching hospitals are beginning to shift, and changes are occurring rapidly.

With the exception of research grants and contracts, and state and local government support for a relatively small number of hospitals, patient service revenue in the teaching hospital is the dollar stream that supports these very necessary societal contributions. Essentially, what we're doing here is subsidizing several functions with revenue from one function. However, these cross-subsidy choices are less and less available as the environment changes to reflect an attitude where competition is strictly on the basis of price. Suffice it to say that although price competition may stimulate prudent decisions by educated consumers and groups with purchasing power, there are not assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet the needs of all our citizens, nor will we achieve the cost containment in the aggregate that we are seeking.

For those of you who are in states where there is competition on the basis of price, I urge you to be cognizant that there are teaching hospitals that will be placed at a severe disadvantage, and more importantly, there are functions and responsibilities in some institutions that may not be able to be continued. There are a variety of ways to finance and develop programs to be sure these responsibilities are fulfilled. For example, in the area of uncompensated care, the eligibility standards for the Medicaid program could be lowered and/or the availability of service could be expanded. Categorical programs for maternal and infant care and/or children and youth could be strengthened. Health insurance for the unemployed could be made a reality. The "revenue pool" approach being developed in Florida is an effort that should be examined closely. Again, I'm not here this afternoon to suggest any particular approach but to be sure these issues get attention. The options available have been set forth in your

excellent publication entitled, "What Legislators Need to Know about Uncompensated Care."

The all payer approved charge systems in New Jersey and Maryland have assisted teaching hospitals with atypical uncompensated care burdens at the same time assuring charges that allow the other objectives I've mentioned to be financed. Many of us have found this to be an equitable approach to meeting our institutional goals and objectives and assuring the citizens of Maryland first rate hospital services at a reasonable price. However, Blue Cross of Maryland recently developed a preferred provider program giving patients financial incentives to use suburban hospitals with little uncompensated care and other costs in their rates rather than downtown hospitals which have substantial costs in our rates for educational programs, standby services, and uncompensated care. This competition in a regulated environment could destroy one of the benefits of the regulatory approach and undermine teaching hospitals.

I wish to leave two major points with you. First, be careful. To the extent price is the driving force behind the effort to keep costs down, you may hurt institutions you may wish to support. Second, it may be necessary to identify other sources of revenue to support the societal contributions of teaching hospitals. I'm pleased to have had the opportunity to appear before you today, and will be happy to answer any questions you may have.

Percentage of Short-Term, Non-Federal Hospitals Providing Selected Services by Membership in the Council of Teaching Hospitals 1980

Selected Services	Percentage of Hospitals Providing		COTH as a Percentage of All Hospitals
	COTH Members	Non Members	
Social Work Departments	95%	69%	7%
Histopathology Lab	94	57	9
Electroencephalography	93	57	9
Diagnostic Radioisotope Facility	91	57	9
Emergency Service			
24 Hour Physician Coverage	91	48	10
As Organized Department	90	70	7
Blood Bank	88	70	9
Hemodialysis—Inpatient	85	18	22
Cardiac Catheterization Facility	83	11	31
Organized Outpatient Department	82	42	10
Therapeutic Radioisotope Facility	80	20	19
C.T. Scanner	80	17	22
Premature Nursery	78	34	12
Radioactive Implants	77	20	23
X-Ray Radiation Therapy	75	15	22
Megavolt Radiation Therapy	71	11	27
Open Heart Surgery Facility	67	6	39
Hemodialysis—Outpatient	66	8	22
Genetic Counseling	53	4	45
Organ Bank	28	2	46
Burn Care Unit	23	1	58

Source: 1980 Annual Survey of Hospitals, American Hospital Association.