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COUNCIL OF TEACHING HOSPITALS SPRING MEETING 1982

5:00 pm, May 12-12:00 pm, May 14
Colonnade Hotel
Boston, Massachusetts

COUNCIL OF TEACHING HOSPITALS
SPRING MEETING
May 12-14, 1982

EVENING SESSION, May 12

5:00-6:00 pm REGISTRATION—
Embassy Foyer

6:00-7:00 pm OPENING SESSION—
Embassy Suite

WELCOME
Mitchell T. Rabkin, MD, Chairman
Council of Teaching Hospitals

KEYNOTE ADDRESS
“THE WASHINGTON PERSPECTIVE:
POLITICAL AND BUDGETARY
EXPECTATIONS FOR 1983 AND BEYOND”
John K. Iglehart, Special Correspondent
New England Journal of Medicine

7:00 pm COCKTAILS AND DINNER

8:30-12:00 MORNING SESSION, May 13

PRESIDING
Mitchell T. Rabkin, MD
President
Beth Israel Hospital
Boston, MA

“REGULATION, COMPETITION AND
PHYSICIAN MANPOWER PROJECTIONS:
THE ISSUES BEFORE US”
J. Robert Buchanan, MD
President
Michael Reese Hospital and
Medical Center
Chicago, IL

“STATE RATE REVIEW AND HEALTH
PLANNING: REGULATORY ALTER-
NATIVES TO COMPETITION”
Bruce C. Vladek
Assistant Vice President
The Robert Wood Johnson Foundation
Princeton, NJ

“NOT-FOR-PROFIT CHAIN OPERATIONS:
ASSESSING THEIR IMPACT AND LOOK-
ING TO THEIR FUTURE”
Scott S. Parker
President
Intermountain Health Care, Inc.
Salt Lake City, UT

“VOLUNTARY HOSPITALS OF AMERICA:
A COLLECTIVE APPROACH”
Allen M. Hicks
Chairman of the Board
Voluntary Hospitals of America
and
President
Community Hospital of Indianapolis
Indianapolis, IN

12:00-2:00 pm LUNCHEON SESSION
“PLANNING FOR THE VETERANS
ADMINISTRATION HEALTH CARE
SYSTEM: IMPLICATIONS FOR THE
PRIVATE SECTOR”
Donald L. Custis, MD
Chief Medical Director
Veterans Administration
Washington, DC

2:15-5:00 pm AFTERNOON SESSION, May 13

PRESIDING
Stuart J. Marylander
President
Cedars-Sinai Medical Center
Los Angeles, CA

“COMPETITION CONFRONTING
UNIVERSITY HOSPITALS: ITS IMPACT
ON PATTERNS OF GOVERNANCE”
Myles P. Lash
Executive Director
Medical College of Virginia Hospitals
Richmond, VA
and
Fred Munson
Associate Professor
University of Michigan
Ann Arbor, MI

“NON-HOSPITAL BASED COMPETITION:
AN ENTREPRENEURIAL VIEW”
Karl G. Mangold, MD
President
The Fischer Mangold Group of
Emergency Physicians
San Leandro, CA

“REORGANIZING FOR OPERATING
AND FINANCIAL FLEXIBILITY”
J.D. Epstein
Principal
Wood, Lucksinger and Epstein
Houston, TX

5:30-7:30 pm COCKTAILS sponsored by
the CONFERENCE OF BOSTON
TEACHING HOSPITALS

8:30-11:30 am MORNING SESSION, May 14

PRESIDING
Mark S. Levitan
Executive Director
Hospital of the University of Pennsylvania

“MARKETING THE TEACHING
HOSPITAL’S PRODUCTS”
Jeff C. Goldsmith, PhD
Director of Planning
University of Chicago Hospitals
Chicago, IL

“NEGOTIATING WITH TEACHING
HOSPITALS: AN HMO POINT OF VIEW”
Robert L. Biblo
President
Health Insurance Plan of Greater New York
New York, NY

“A SUMMARY REVIEW AND SOME
THOUGHTS FROM A DEVIL’S
ADVOCATE”
Robert A. Zelten, PhD
Associate Professor
The Wharton School
University of Pennsylvania
Philadelphia, PA

11:30 am Adjourn

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**COUNCIL OF TEACHING HOSPITALS
SPRING MEETING
PROCEEDINGS**

**Boston, Massachusetts
May 12-14, 1982**

one dupont circle, n.w./washington, d.c. 20036



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association of american medical colleges

"NEGOTIATING WITH TEACHING HOSPITALS:

AN HMO POINT OF VIEW"

Presentation by ROBERT L. BIBLO

Thank you. It is a pleasure to be here. I had intended a low key presentation -- but I think that after the warning given by our previous speaker, I will come on a little more strongly.

I note that I will be followed on the program by Bob Zelten. Bob's thrust will be that of a devil's advocate. To be the speaker prior to someone who presents as a devil's advocate can be somewhat disconcerting. But I have confidence in Bob. I've known him for many years and he has done a very unusual thing. He is an academician, but an academician who has published several useful and practical papers.

I would also point out that what I have to say has to be kept in perspective. It's all a matter of who's talking to whom and at what point in time.

It's somewhat similar to Sergeant Preston's very famous law of the Yukon that some of you may or may not have heard -- it goes something like this -- the scenery only changes for the lead dog! So please view my remarks from the position you're standing in.

HMO/teaching hospital relationships are not amenable to cookbook resolution. They are dynamic relationships and they will be as different as the differing parties involved. While it is possible to state some broad concepts which should underly any HMO/hospital relationship, it must still be remembered that in the end it will be the parties involved and their respective needs which will really make the difference.

I recall, for example, the time 12 years ago, in 1970, before that word, "Health Maintenance Organization", was coined, (something I never will quite forgive Paul Ellwood for). Before that word was coined, the Harvard

Community Health Plan was trying to get off the ground. For reasons involving principle, (there were no big dollars involved) the question of whether to affiliate with HCHP was a hot issue. For some reason or other, Beth Israel and Peter Bent Brigham, two Harvard affiliated hospitals, decided to throw in with us and to help us. Another major Harvard affiliated hospital decided they didn't want to.

As I stop and think about it, it really was the individuals involved who made the difference. The hospitals were not being asked to make a significant financial decision - HCHP was just too weak to prevent a make or break decision. All three institutions had "revolts from the admitting staff", the private staff, that wasn't going to tolerate affiliation, and yet, two decided to come through for us, and helped us with physician recruitment, and availability of beds and reputation and marketing and so forth, and one did not. It really was individuals that made the difference.

Before going further, there are a few points that I'd like to mention. These are related to our topic, but in a tangential way. However they could have a significant bearing on how hospitals, teaching hospitals, and HMOs will relate to each other.

If the reports of the Graduate Medical Education National Advisory Committee, (the GMENAC study which predicts a heavy oversupply of physicians, by 1990, and marked surpluses in most surgical specialties) is reasonably accurate, then HMO's have to bear in mind that there will be increased competition for hospital beds and hospital relationships. Traditionally, an oversupply of physicians means increased hospital utilization, increased costs and increased physician fees and so forth. Thus hospital beds may be severely limited and the HMO may be in the position of having "to wait its turn" for access.

From a practical point of view, however, this is not a satisfactory answer in an operational program where you have to get physicians on staff and people in a hospital bed. An HMO has to face the practical reality of limited beds, that we don't have places that will admit our patients, or we don't have institutions that will take all of our physicians so we are not able to centralize admissions. Thus it is imperative that an HMO seek to work closely with the hospitals it seeks to utilize.

From the hospital side, HMO development will continue. Now the growth rate is 15% a year, with 8 million of the 10 million HMO members being in the prepaid group practice model -- the model that I generally am referring to.

If this development continues, it is conceivable that HMO's at one point in time in the not too distant future might constitute 20% of the market. This is a substantial piece of the market. Certainly the hospital that ties in to that, that comes first, that develops the relationship with the HMO first will get most of the HMO's business. From a planning perspective, if you're interested in the business, that is a reasonable point to consider. I will discuss that a little later on. Some hospitals may not be interested in the business.

Then there's the public policy issue. Many of my good friends, Alain Enthoven, Paul Ellwood and Walt McClure -- are at the forefront of the pro-competition strategy; the belief that competition is going to correct many of the ills concerning high medical costs.

The economists have published on it and believe in it. However, I have seen no significant results to justify that position except where there is some competition between systems of care. This is in the limited context where prepaid group practice has impacted positively on the fee-for-service

system and where these two systems of care compete effectively. Where this has occurred, we've seen some impact on the fee-for-service system relative to reduced hospitalization, as well as broader benefits being offered. However, only in the instance of such competition has "competition" in fact produced the results predicted.

I expect the competition proposals to decline in their popularity. At the same time prepaid group practice as a successful model of competition will increase in its popularity. Prepaid group practices are growing and interest in them is rapidly increasing. I suspect one of the primary reasons for this, although I don't have a study to prove it, is the inflation in the field and the public's perception that prepaid group practice represents good value for the health care dollar.

To put the inflationary impact in perspective: In 1972, General Motors and Ford paid \$1,300 per employee for health care benefits; in 1980, it was \$3,000. Or, to put it another way, in 1972, \$125 for every car went for health care benefits; in 1980, it was \$315 per car. Inflation at that magnitude can hardly be ignored and it's not.

Let me now turn to the question of HMO/teaching hospital relationships and some of the key issues in developing such relationships. From a very practical point of view, who the dominant force is, at a given point in time, is going to determine, to a large extent, how that relationship develops. HIP includes within its system a teaching hospital. The hospital has a strong tie with Cornell/New York Hospital, which we don't control, and that relationship was developed because of a common need.

But in terms of the relationship between HIP and LaGuardia Hospital, that relationship is largely determined by HIP.

Conversely, some hospitals have sponsored HMO's -- usually it's thought of as a line of business for the hospital, or as a means of increasing business for the hospital, (which I think is somewhat inappropriate in the development of an HMO). There, the leverage in terms of the relationship between the HMO and the hospital is held by the hospital.

If we go beyond these examples, we move into a less clear area. This is one in which neither the HMO nor the hospital controls the other. Here there are conflicting dynamics that motivate the two organizations. The previous speaker touched on some of them; let me see if I can expound on a few more.

Hospitals seek increased hospital income. Some question how you do that, one answer of course, everybody's favorite, is the patient who carries an indemnity insurance policy. But while hospitals seek increased hospital income, HMO's seek to reduce hospital expense. That's a conflict. It's a tough one, but I think it can be reconciled.

Another conflict lies with the public the entity is attempting to serve. HMO's appeal -- or try to appeal, and to satisfy the needs of, their consumers in a more direct manner. Their consumers can march any time they want, they can belong to the HMO or not.

Hospitals traditionally view their public -- their major public to appeal to and to attract -- as the physician. The hospital is the physician's workshop. The physician admits the patients. If you have the physicians, you get the patients and if you get the patients, you get income.

The conflict relating to income, e.g., the hospital's desire to increase income, through increased inpatient use, versus the HMO's interest in seeking to reduce hospital expense, usually comes to a head in the nego-

tiation process and is often demonstrated by the disagreement over the reimbursement formula. How do HMO's reimburse hospitals?

At times the HMO has no choice. You pay what the hospital says you'll pay. That's where the HMO is weak. But usually there is negotiation.

In addition, another conflicting dynamic that motivates the two organizations -- has to do with the way they are reimbursed. This involves the dynamics of cost reimbursement versus prospective budgeting. The latter has to do with controlling utilization and making sure that unnecessary utilization is minimized while the former looks to increasing utilization to increase income. Another way to put it is -- the need to fill beds versus the need to reduce hospitalization.

The HMO's commitments to teaching and research, if at all, are secondary to its needs to be price competitive. Moreover, HMO's often seek to use teaching hospitals only for tertiary level care while the teaching hospital argues that it is impractical to be limited exclusively to tertiary care.

Depending on your perspective, HMO's can have a negative impact on teaching hospitals. HMO's look to use lower community hospitals. They look to substitute ambulatory care for inpatient service where medically appropriate and to provide ancillary services on an ambulatory basis rather than in a hospital whenever possible. Moreover the HMO often enrolls individuals who may have previously received their primary and specialty services from the hospital outpatient department thus diverting this source of income. Finally, on rare occasion, the HMO may seek direct ownership of a hospital and thus place itself in direct competition with a hospital.

Thus in any negotiating process between HMOs and hospitals, there need to be recognition of the fact that each entity has at least some con-

flicting concerns and needs. Moreover, the HMO's needs, the needs of the HMO community at large, the HMO's physician's needs, cost factors, the power relationships between the two organizations, (and those power relationships are often determined by the availability of hospital beds in the community), the size of the HMO organization, the financial position of the two entities, the regulatory environment, and the numbers of fee-for-service physicians in the community all play a contributing role to this process.

Can these differences be overcome? I think they can if each looks at what the other wants. Is there a commonality of purpose?

Well, in broad perspective, both are interested in providing quality medical services, or at least they should be.

The hospitals have beds, and the HMO has patients regardless of how you flip the coin and how often a hospital has to be used, some patients need to be put in a hospital.

The ideal situation -- if one wants to look to an interlocking relationship between the two institutions -- is to develop unique reimbursement formulas, and we're just starting to get into this area.

Capitation arrangements appear to be ideal where state law and state regulation will permit it. HMOs also could guarantee the occupancy of certain beds or pay the fixed costs of the unoccupied bed using a unique financing formula.

To the hospital, this also means no bad debt -- and a guaranteed source of steady income.

Another area of commonality involves, if possible, a specialty referral. The HMO can be a source for patient referral to the hospital's physicians. Where a reasonable arrangement between the two institutions is arrived at, HMOs very often will use the hospital specialists as their referral source.

If in fact an arrangement between the institutions are satisfactory, the HMO usually will agree to a fiscal arrangement for use of the hospital's emergency room as the emergency service source for the HMO.

What special efforts can a hospital make to win an HMO's support? I think if there was ever a point in history that hospitals ought to be thinking this way -- this is the time. HMO's are growing, and particularly in urban areas. Whoever gets there the first gets the most. If the relationship with the HMO is marginal, there will be no commitment. The HMO will move and change its relationship as soon as it gets a better offer. Good management techniques simply demand such an effort.

The HMO is looking for a relationship with a hospital that will add to the HMO's image, so public relations are very important. A hospital's reputation, vis a vis technical excellence, and patient amenities are very important to an HMO. Remember to the HMO member, the hospital the HMO utilizes is a reflection on the HMO itself.

A teaching hospital can be, if it wishes to help -- (and I use the examples of Beth Israel and Peter Bent Brigham hospitals in Boston as good examples) -- a major source for physician recruitment for the HMO, particularly young physicians, those just completing their residencies, if the relationship between the hospital and the HMO is one of mutual respect.

To develop adequate organizational relationships, the ability to press the right buttons in each organization to solve problems, is also vital. HMO's need good information -- they must manage very carefully, in terms of utilization review; they have to have an information exchange which will allow them to know who's in the hospital and at what time and for how long.

It means that the commitment from the top must be that you can get to the top, or make sure that middle management recognizes that it is part

of the hospital's goals and policy to relate closely to the HMO; that they get the message, and provide information and relate to the HMO's complaints and questions and members in a very careful and caring manner.

Staff privileges are also a key ingredient. This gives the HMO the ability to centralize admissions, is cost effective and permits maximum use of HMO physicians for care of HMO members. It means that the medical group can actually function as a group, a dynamic which is not possible when an HMO is forced to hospitalize in a decentralized manner.

The coordination of the hospital program as part of the HMO marketing effort -- if the hospital says you can come in through the back door, but don't talk about us -- it's a relationship you accept if you have no other alternative. But if the hospital is a part of the marketing effort and will be willing to be part of the literature, part of the HMO's presentations, even to the point of making joint presentations if it is willing to give testimony to the quality of care, then the hospital can become a major friend of the HMO, because HMO's are marketing organizations and the hospital can be an important part of any marketing effort.

HMO's are also concerned with the attitude of individuals they must do business with. A weak administration in a hospital is a turnoff for an HMO. An HMO's inability to get action is very, very costly; an inability to respond to complaints, an inability to at least buffer the hostility of the hospital's private physician staff to HMO's physicians are something HMO's can't cope with.

For a hospital administration that wants to be identified with you in a marginal way, our view of life is that we'll go away as quickly as we can. But this is not a desirable or desired relationship for an HMO. And at this stage of the game, what we look for or tend to look for is not only

a strong administrator, but also a board of directors that will be supportive and which will, if necessary, intervene on our behalf.

We no longer accept the role of second class citizens in any institution. That's our national policy. Equally significant, where smaller HMO's are forced to play that role, they will remember it, and if they gain in strength and desirability, the hospital can then kiss that HMO goodbye.

The ability to penetrate the hospital hierarchy can often make a major difference. Through the nine years of the Harvard Community Health Plan, from the day when we had zero members to the day when I left, when we had about 75,000 members, I always know that at any time I could call Dr. Rabkin at the Beth Israel or Dr. Hassan at the Brigham, and that I would get through and would get needed action.

There were some other institutions that we had to identify with as we expanded, and with them we were not able to develop the same kind of relationship.

I'm not trying to say that the Harvard plan can be replicated all over the United States. It can't.

But what I'm saying is that those relationships are a good example to look at because the relationships can be replicated in other parts of the country if the parties are willing. To date, hospitals are not, unfortunately, learning these lessons.

The ideal arrangement also involves sharing of risk. That really puts the two organizations together. If the hospital is willing to share risk, assuming state law and regulation allows it -- then the two organizations will have a clearer commonality of purpose. The risk would be that a capitation arrangement did not fully anticipate inflation, or that the HMO used more days than had been assumed. But sharing of risk is not all downside for the hospital.

Sharing of risk also means sharing of savings. If, for example, the capitation was more than adequate because of superior HMO cost performance or hospital performance, then the hospital shares in the savings generated.

Finally, and this may somewhat coincide with what the previous speaker had mentioned, a positive HMO relationship prompts the hospital to think about redefining its mission in positive way. An HMO's presence, with many HMO patients, and the kinds of review programs and attitudes that HMO physicians may bring to the hospital in terms of cost effectiveness and patient care -- may help the hospital to more adequately deal with the new demands society is placing on the health care sector in terms of controlling costs.

What are some of the HMO's selling points to teaching hospitals? The larger you get, the stronger you get in terms of these selling points.

First, HMO's may be willing to participate in the cost of teaching programs. If there are other tradeoffs that help the HMO to be cost effective, some of the dollars saved can then be diverted to teaching.

Second, the ability of HMO physicians to participate in teaching programs, and to extend teaching to the ambulatory setting. It's now argued, and there isn't much disagreement, that teaching cannot be limited to the inpatient setting.

HMO ambulatory centers are excellent places for teaching. This is the kind of care that most physicians will be involved in throughout their careers. In general, this means participating in the cost of medical education. There are some advantages to this; if you have residents around, very often the residents provide an exciting and challenging environment for practicing physicians.

HMO physicians will actively participate in the professional committees of the hospital, and secondly, and another significant point -- where HMO's will traditionally look for community hospitals for admissions that don't have to take place in a teaching hospital, they may change their mind if the teaching hospital relationship is strong enough, and if there are other factors relating to programs the HMO may develop, such as early discharge programs, surgical nurse programs, homemaker services and so forth. The HMO may make the commitment to admit all members in need of inpatient care (the whole case mix issue) -- or as an alternative, it may admit to a community hospital with a tie-in to a teaching hospital. This of course would also be in the interest of the teaching hospital.

As stated, if the parties agree to an effective management relationship, the higher per diems charged by the hospital can be partly offset by strong monitoring of admissions, length of stay and by instituting alternatives to hospital care.

Strong support by the hospital for HMO development can lead to the hospital getting most of the inpatient business the HMO generates. But the hospital must then redefine its mission. The point I tried to make earlier. If the relationship is strong enough and the benefits are mutually advantageous, the HMO can then effect other kinds of programs with the hospital which would make it worthwhile to centralize its admissions in that one institution.

HMO's can (for a particular institution) also make a difference in terms of converting a marginal service to a sound one. Many hospital departments (i.e., obstetrics) do not have the occupancy required by state regulatory bodies. By capturing an HMO population the HMO can provide the case load that could preserve a particular service otherwise deemed to be inadequate.

The HMO in relating to a teaching hospital, usually finds the teaching hospital relationship the easiest to mold into marketing programs for the HMO's population. HMO's often have to face unreasonable criticisms; i.e., only the inferior doctor will join the HMO; only the lazy doctor will join the HMO, etc.; after all, if one wants to find out about an HMO and its quality, who would you normally run to? You'd run to your family doctor, and to no one's surprise, the family doctor will say, "Oh, you don't want to join the HMO!" The teaching hospital relationship provides great strength to the HMO in countering that argument in presenting its program to the public at large.

There are a few other areas that might be of interest to you. There is a possible sharing of staff, and the sharing of equipment. Even common medical records and common recruitment can take place.

But all these strategies really depend upon the good faith of the two organizations and the recognition that there are different dynamics that motivate the organizations. The key to the success of the relationship is to find out whether there is an overlapping interest.

A very famous physician who was once associated with HIP, the late Caldwell Esselstyn -- many of you may have heard of him -- used to say that we in this country ought to be grateful, very grateful, to our Puritan and Pilgrim forebears who came to this country so that they could worship as they chose, and make damn sure everyone else did the same.

I am not trying to mandate a formal position. The message that I leave you with is that these relationships are complex and they relate to different dynamics. However, if there is strong recognition on the part of the HMO and the teaching hospital of each other's needs and differences, and a spirit of cooperation and respect, it is possible to develop relationships

Mr. Biblo

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which are sound and mutually beneficial. In this instance a commonality of interest can be developed and with positive results.

Thank you.



association of american medical colleges

"REGULATION, COMPETITION AND PHYSICIAN MANPOWER PROJECTIONS: THE ISSUES BEFORE US"

Presentation by J. ROBERT BUCHANAN, MD

Ladies and gentlemen, colleagues, and distinguished guests.

Early in the year 1776, before Thomas Jefferson had begun to compose the Declaration of Independence, a countryman of my ancestors came down from the hills of Scotland to publish an economic treatise that was to blow fresh winds into the course of human affairs. In his analysis, which was to become revolutionary in its own time, and which attempted to ascribe an unseen order to the seemingly chaotic conditions of daily economic life, the author observed that the price of every commodity brought to market depended upon the quantity available and the demand for it. How simple.

The author was, of course, Adam Smith, and the book was The Wealth of Nations. Its descriptions of economic competition and the mechanics of the free market still reverberate in our time--even among those who worry about the provision of health care to Americans in 1982. We do not know for certain that Ronald Reagan purchased one of the early copies of The Wealth of Nations soon after its publication, but we do know that his policymakers, and those who provide him with ideological stimulation, have read Mr. Smith--as well as Professor Friedman, Professor Enthoven, and a body of lesser lights with similar ideas.

Indeed, competition and the unfettered marketplace are terms which are no longer out of fashion in the United States. They have survived virtually a half-century of liberal, social welfare policy and have surfaced once more as an antidote to or a presumed solution for many of the social and economic ills that plague our nation. It would seem to be an oxymoron that among those ills is health care--or at least the perceived high costs of health care to our society.

Those of us who are involved with delivering care might have seen such a policy coming for years, had we only been able to raise our noses from the Federal Register long enough to consider alternatives to the regulatory system imposed upon us. What I aim to do this morning is to trace briefly the events which brought us to the present crossroads, then to consider the impact of the alternatives upon the future of our system of medical care, including the welfare of patients and providers in this country, and finally to tell you what I think our direction should be. I have been asked to provide you with an overview of these matters, but I hope you will understand that I cannot escape my own convictions.

The record of our "industry" over the past three decades is largely one of superb response to societal demand. The most important point to remember is that the origins of the burgeoning expenditure for health care in America, both in real dollars and as a percentage of the gross national product, lie in attempts after the Second World War to expand medical research and medical education, but most of all to democratize the health-care system in the United States. Much as it may sound like another corny textbook notion, democracy has been a fine thread running through the fabric of the history of this Republic. It was Dr. Benjamin Rush, one of the fathers of American medicine, who observed in 1798 that equality among mankind was at the very soul of republicanism.

Almost two centuries later, the Medicare and Medicaid programs instituted by the federal government and most of the states of this nation were efforts to provide a single standard of health care in this country--that is, to provide an equal quality of care wherever possible, but at least equal access to care for all citizens, especially the poor and the elderly. This was the real meaning of Medicare and Medicaid, and physicians and hospitals responded with a greatly

expanded system of delivery. The expansion was fueled by government money aimed at providing, if I may repeat, at the very least, equal access.

Did the program work? You needn't take my word for it. Here is an appraisal from Dr. Robert Blendon of the Robert Wood Johnson Foundation and Thomas W. Moloney of the Commonwealth Fund. "Medicaid," they say, "is a far better and more indispensable program than commonly realized: it serves a broad cross-section of the American people, it probably does improve health, and its program costs per recipient are not higher than the per person costs of care for all Americans of similar age."

Medicare and Medicaid have also contributed to a rise in the level of health care in subtle ways not generally recognized. First, they substituted payments to doctors and hospitals for what used to be free care and bad debts. Second, in replacing no payment with payment based on cost of production or on reasonable charges by professionals, they helped to fuel cost inflation and rate increases. In other words, especially in the provision of staff, technology, and facilities, institutions were able to do things for all their patients--including their charge-based patients--which they might not otherwise have been able to do.

In hand with this new emphasis on access to care came a new mood among health-care consumers. The times, remember, were the prosperous 1960's, when incomes and resources were relatively abundant, and when persons whose health care was paid by a third-party insurer could afford to be particular and demanding about medical services. Workers wanted greater coverage. Business rarely questioned the inclusion of rising health insurance premiums in the collective bargaining process. Cash flow in virtually every office, agency, institution, and corporation having to do with health care ballooned, and so did costs. Extraordinary technological advances helped to expand this inflation. In the

mid-sixties, when Medicare and Medicaid were implemented, health-care expenditures in this country amounted to \$42 billion, or 6.1 percent of the gross national product. In 1980, we spent \$247 billion on health, or 9.4 percent of GNP. We are now at about 10 percent of GNP. And during this time, per capita health expenses have risen from \$212 to more than \$1,200.

Governments--which are in the habit of demanding accountability in return for dispensing funds--moved swiftly in the 1960s to establish controls through regulations. Thus the regulatory system became entrenched, to ensure equal access for those citizens under Medicare and Medicaid, and to establish fiscal accountability for the program. As we shall see, whether the regulations really provided incentives to control costs was quite another matter.

In this new equation, the physician was no longer a free agent. Not only was he to care for those patients who would not previously have been able to afford his services, but to the extent his bills were now to be paid by the government, he was to toe the regulatory line while providing his services. Government was also to intrude on the economics of his profession by determining the supply of his expertise. If more of the citizenry were to be cared for in a more equitable manner, then more physicians must be available to do so, and they would be needed not only spread across the specialties but spread geographically across the countryside as well. As a consequence, government support influenced medical schools to expand enrollments in order to enhance markedly the supply of physicians in the nation, especially primary-care physicians. Active physicians numbered 323,000 in 1970; the projected figure for 1990 is 600,000, of which 42 percent are expected to practice in primary care. Throughout the 1970s and until the present moment, this expanded supply has not become a critical factor

in the economic welfare of individual physicians. In the decade of the eighties, however, it seems likely to do so.

What are we to make of this scheme which the nation's health-care institutions and the government and the doctors have built? We all know that we have been wailing about the weight of government regulation for years now--until we began to consider the alternatives. At that moment, the regulated system, like Linus's blanket, suddenly offered a comfort and security it had not had before. In fact, regulation has accomplished a good many of its aims. It has enhanced access to care, and while it may not have succeeded in equalizing treatment across socio-economic barriers, it has certainly narrowed the extremes of treatment so that most Americans are closer to a desirable norm. Has the norm fallen? On the contrary, I think medical care, unlike education, has not suffered a lowering of standards by making itself more available to more Americans. The quality and sophistication of health care have been raised spectacularly over the past two decades.

Where regulation has been less effective is in providing sufficient incentives to restrain costs. It has failed to temper the cost problems generated by third-party payors and complicated by the physician's role as a consumer in hospital care. Between 1975 and 1980, annual health costs rose much faster than inflation. Last year Medicare alone cost \$42 billion--as much as the nation spent for all its health care when Medicare began; and by 1988 Medicare is expected to cost \$100 billion. Doctors have, by and large, prospered under the regulated system, much as they may have feared it at the outset. It has brought them more procedural headaches but considerably more influence and income than they had imagined.

Meanwhile, how fares the consumer, who is often the last to be queried about his opinions of the present system? In truth he fares quite well, thank

you, and in national polls will tell you that he generally approves of the health care he receives. Even more interesting, while pundits and policymakers at the national level lament the total monies spent for health care in the United States and devise all kinds of stratagems to deal with these shocking figures, the individual consumer rarely complains about the amount of money he spends for health care. Faced with a choice, he votes with his pocketbook: he usually chooses to pay more for better care. More often, some third party pays the bill for him. The individual consumer's desires are a curious and almost secret aspect of the debate over health costs. The social perspective submerges individual perceptions: the whole is not equal to the sum of its parts.

I think it is fair to say that institutions have largely benefited from the regulatory process. Certainly we have suffered from the uncertainties and vagaries of retrospective rate setting. And certainly we have assumed enormous costs of responding to the regulatory process. But overall I would argue that in spite of burdensome regulations and a quixotic operating climate, we have been able to enhance the delivery as well as the quality of health care for all Americans, especially those who can least afford it. Moreover, as Eli Ginzburg recently observed, until this year we have done a reasonably conscientious job of containing costs, particularly in the midst of a cruel inflation.

While we have gained some rewards from reimbursement regulations, it is difficult to say what we have gained from regulations designed to oversee a wide range of other of our activities. OSHA, ERISA, and other similar monitoring agencies have had an exceedingly questionable impact upon the well-being of our institutions or our employees or our patients. And in recent years, we have been adversely affected by the inflexibility of the regulatory system in responding to a growing scarcity of resources. It may be argued that regulation has made our

country's entire industrial complex less able to compete internationally, and thus has contributed to a withering of the entire American economy.

The physician's response to the democratization of health care has been impressive. Not only do we now have more physicians to care for the population than we did before, as a result of the growth of medical school classes, but we also have better distribution across the specialties. It is less clear whether we have achieved a more equitable geographic distribution. During the 1970s, the population of the rural areas of the country grew by 15 percent. Even though the number of medical students doubled in that decade, the relative shortage of physicians in rural areas is likely to persist. Many rural and small-town areas have less than one general practitioner per 3,500 population, which is the federal government's definition of a health manpower shortage.

It is also unclear whether the physician's response to equal access and the regulated system has affected the costs of health care, and if so, exactly how. We do know that the physician in the hospital setting has virtually no incentive to hold down costs or his own fees. Astute observers such as Eli Ginzburg believe that physicians generate about 70 percent of health-care costs, and that the expected glut of physicians is thus likely to increase health-care costs to the society, even though only about 20 percent of those costs end up as physician income.

Costs are clearly the bone in the throat of social policymakers and the primary motive for the ongoing debate over a new system of health care in this country. Although the government funded a system to provide better access and better care for the vast majority of Americans who hadn't been adequately served, it now finds the costs of that system unbearable. Ten percent of the gross national

product and 11 percent of the federal budget are unacceptable to social policymakers even if individuals do not find their own costs too high, and even if our expenditures for health care as a percentage of GNP are lower than those reported for the Soviet Union. In Illinois the governor has recently proposed a fiscal year 1983 budget in which the state's Medicaid expenditures for hospital care have been cut by an appalling 29.8 percent below the best estimates of reasonable need.

We should not ignore the political and economic climate in which most of the proposals for change are being floated. We are silly if we believe that the Reagan administration is exercising an ideology or an attitude in opposition to most of the American people. The administration may be carrying a rag-bag of laissez-faire ideas which seem out of place in a post-industrial, multi-national age; but the fact is that Mr. Reagan was elected precisely because he espoused these ideas. For us to think that we may be able to "survive" Reaganomics and live to prosper in old-fashioned ways under new administrations is to ignore widespread political realities as well as those real costs that stare us in the face each day. In fact, the regulated system has failed to produce incentives to control costs, and we ought to want such incentives if we are to avert the kind of government intrusion that would cripple a highly valued social benefit. The health-care industry is not on a kamikaze mission against the federal government.

Just what is competition supposed to be, anyway? Who's competing for what? There is as much confusion over definitions of this term as there is over the potential effects of putting competitive mechanisms in place.

At its root, the concept of competition calls upon the mechanisms of a free marketplace to determine levels of goods and prices in response to supply and demand. This most every schoolchild knows, and it is in some ways a cornerstone of the Republic.

Nonetheless, competition as proposed in the delivery of health care would pit institutions against institutions, physicians against physicians, insurance companies against insurance companies, and--most important--all of them against all of them, the resulting battle redounding somehow to the benefit of the consumer. When the smoke clears, what we should expect to see are fewer hospital beds, a more equitable ratio of physicians to consumers, lower fees, lower hospital charges, and lower insurance rates. All this is to be achieved, of course, in the midst of inflation which is expected to continue, even if ameliorated. But any plan that promises to contain escalating health-care costs by using market forces rather than more bureaucracy is certain to be attractive.

What are the assumptions of the exponents of competition? A good many of them are dubious, it seems to me, which does not augur well for the propositions which flow from them. The principles of the marketplace work best in classical models. When neither supply nor demand is controlled or regulated in any way, and when the goods in question are somewhat more tangible and less essential than health care, competition may well produce model results. Is anyone here today ready to agree that the health-care system is a classical model? I can't imagine a system further removed. The "hidden hand" of the marketplace doesn't determine price in health care, probably never has determined it, and probably cannot ever determine it. Health-care consumers do not behave like the marketplace models of Mr. Adam Smith. The characteristics of this regulated and complicated system of ours have baffled the smartest of our business leaders on boards of trustees throughout this country, and these characteristics also play havoc with the theorists and forecasters of competitive models. Too much of the analysis produced by competition advocates is conjecture--and theoretical conjecture at

that. Too many of the theoretical competitive plans are riddled with economic uncertainties which are likely to cause us nothing but trouble in real life.

The most celebrated proposal for competition is that of Alain Enthoven. As you know, it contains four main points. First, it would reform the tax laws so as to place a ceiling on the deduction of health insurance premiums by business. Presumably this would end the encouragement of high-cost health plans and instead would promote economies by taking advantage of competition among plans. All this reform would clearly warp the collective bargaining process and might disrupt union-management relations across the country, but I must say that I find it to be a reasonable starting point. It hits the employee in the pocketbook, where he must be hit to appreciate the costs of his health care, and it makes it more difficult for business to bestow further large benefits as they have done in the past.

Second, Enthoven proposes that employees be offered a number of different plans at various price levels, and, most important, that the employee be allowed to pocket the cash difference if he chooses a less expensive plan. This is an intriguing idea. But competition in selling health insurance is not new, and consumer behavior in this instance is by no means predictable. We have plenty of evidence to show that, given a choice, the consumer more often chooses the expensive plan because he wants maximum coverage at relatively little additional cost. In a larger sense, if the public is now so generally satisfied with its care, will the individual shift to another system to save 15 to 20 percent? Maybe, maybe not.

The third feature of the Enthoven program calls for more co-payments and deductibles. In other words, let's get the consumer to realize that his health-care decisions affect his own pocketbook. I happen to believe that

Enthoven is correct about this, but I have one ear tuned again to Eli Ginzburg who tells me that the American consumer, irrespective of age, has repeatedly chosen first-dollar coverage when he can get it.

Finally, recognizing that we do live in the late twentieth century, and that those who cannot afford health care cannot simply be left to expire, Enthoven offers special coverage for low-income people. A system of grants or vouchers would assure them of the right to receive the care they need. This feature of the program points up a problem to which I shall return later, which is that competition does not beget more competition so much as it begets regulation. We do not have a perfectly free marketplace, either for poor consumers, teaching hospitals, or rural physicians, among others. If we do not wish to begin dismantling the American social and economic structure altogether, we must be able to offer protection to selected institutions and individuals who will find themselves at a disadvantage in a newly imposed competitive system. Regulations will be needed.

In fairness to Enthoven's arguments, he understands this. He does not envision a totally free marketplace, and he acknowledges that regulations must play a role in creating what he calls "structural incentives" to reduce costs.

Two other elements of the competition argument do not receive much attention from Enthoven, but they should be considered. One is the suggestion that much heavier emphasis be given to the building of HMOs as a cost-containment measure. HMOs have the superior advantage of prospective reimbursement. But they have too many significant disadvantages to be a panacea. Whatever their attractions, they have managed to enroll only about 4 percent of our population, and indications are that by 1990 they will not enroll more than 10 percent. HMOs fit well only

in certain geographic areas, and they haven't yet helped to constrain general health-care costs. While some evidence indicates that HMOs may reduce local hospital utilization, HMOs haven't yet demonstrated that they can successfully care for the poor or for a large Medicaid clientele. Many consumers resist them because they believe that good care is expensive. What's more, an HMO's economic advantage to the consumer is greatly diminished if it is the only HMO in the area, because the lack of competition causes premiums to rise like warm air.

The other consideration, ignored by most save Bob Sigmond of Blue Cross, is the role of voluntarism in the effective administration of whatever system we have, be it regulatory or competitive. Too little attention has been paid to the role of voluntary forces in establishing tougher standards of care and mechanisms to maintain performance as good as or better than such standards. It's not competition that has maintained standards of quality and safety, it's voluntary control in cooperation with government regulation. The same is true in guaranteeing access to those who cannot afford care. Private institutions have maintained this access with difficulty, under trying financial circumstances, and have been faithful to their communities despite the recent heel-dragging support of government.

Now, the whole of the competitive program, it seems to me, is often characterized by an earnest disregard of the unpredictability of human behavior and the deeply ingrained humanistic motivations of the health-care enterprise. Emanating from these presumably hard-headed economic realists are proposals which are frequently based on the sheerest hope, which ignore painfully accumulated experience, and which almost invariably promise deliverance in highly uncertain terms. The predicted benefits of the competitive model are that costs will be reduced. But this is by no means clear because of unknowns in the equation. We

do not know that consumers will choose lower-cost care; we do not know that competitive forces will eliminate excess hospital beds; we do not know that competing insurance plans and HMOs will succeed in reducing hospital charges; we do not know how physicians will react in competitive situations with hospitals and with other physicians; and we do not know how teaching hospitals will pay for the non-patient-care services they perform.

The social costs of a new competitive system might very well not be worth the dollar benefits achieved. Competition is not necessarily socially productive. Clearly, the competitive system would reverse the nation's major effort to move toward greater democracy in the delivery of health care. There is little question in my mind that it would move us back along the path toward a two-tiered system, and would begin to dismantle equality of access to care. There is nothing in the theory of competition to ensure that essential medical care for the poor and the isolated will continue to be available.

Beyond this most critical consequence of the competitive model, I believe we must also recognize that the general level of health care is likely to suffer. Most of us here realize that our patients who pay on the basis of charges help to support our patients who pay on the basis of costs. This is not one of the happier features of the present regulated system, but it is a kind of enforced charity which has permitted us to provide a sophisticated level of care for all our patients. Under competitive circumstances, these additional charges are not likely to survive. The result will be a lower standard of care for all patients.

I am not optimistic about the prospects of competition in providing for accountability by institutions and physicians to the general public, in providing for a measure of fairness and due process in decisions involving the public interest,

and overall in securing the stability of our delivery system. For teaching hospitals particularly, the advocates of competition have yet to articulate the means by which our proven societal contributions will be preserved. Even Enthoven admits that the teaching and research costs of major medical centers ought to be separately identified and subsidized under a competitive program. Who will pay us for the training of physicians and for the performance of basic medical research? If we must compete for patients against the price structures of community hospitals, who will fill our beds? And who will care for the poor?

If we are to institute a system that is totally price sensitive, those institutions that seek to do more, whatever the area of endeavor, will be at risk. Punishment for ambition? That's a situation highly uncharacteristic of a classical competitive mode. It points up the difficulties of applying marketplace strategies to the intricate mechanisms of our health-care system. I have yet to see the competitive proposal which accounts for the non-patient-care activities of our institutions, or which recognizes that, in the end, quality of patient care depends upon these activities. Doing more is crucial to the quality of the system we have built. Teaching hospitals make up only 5 percent of all the hospitals in this country, yet they admit about 20 percent of all inpatients, care for 31 percent of all outpatients, operate more than 33 percent of all intensive-care nurseries, do 40 percent of all open-heart surgery, and account for more than 50 percent of all burn units. Teaching hospitals in particular cannot endure in a system that won't pay for doing more, a system that homogenizes medical care to a common pabulum.

If there is one sure conclusion we can draw from examining the various proposals for competitive health-care systems, it's that no totally free market

plan will work. The uncertainties are too great, hence the risks are perilous for the profession and ultimately for the American consumer. Even the fiercest advocate of the marketplace approach will admit that it should be used only to put incentives into the system, and that some degree of regulation will still be necessary. This is the kind of system I believe we must have, one which combines elements of competition, regulation, and cooperation. I believe we must be ready to build competition into our delivery system in order to produce incentives and mechanisms to control costs. But we will need regulation to ensure that there is equity in the system for consumers, physicians, and institutions. And no system will work without the voluntary cooperation of providers who, if they are to continue to pursue excellence and exceed the average, must still believe they have sufficient control over their own destinies.

The kind of system we want, it seems to me, has three major objectives. First, it will provide more than a merely adequate quality of care. It would be easier to design a system which provided only acceptable care for all its patients. I think none of us in this room would want to see that kind of system.

Second, a workable system ought to provide, as near as possible, equal access to care for all consumers. And third, the system ought to have built-in mechanisms for self-improvement, specifically, investments in research and education which take some account of the future rather than dealing only with the present.

Now, I believe we can best achieve these objectives through a system of prospective financing. I believe a prospective approach would successfully limit resources, would provide for public scrutiny and informed government decision, and would allow for rewards for excellence and good management. I believe that

any such system should include consumer participation in the payment process so as to make the patient a more enlightened participant in cost-containment. But government must provide for those who would be unable to pay for even a portion of their care, and it must not sluff off responsibility for the poor onto those institutions which have traditionally assumed this responsibility. We ought to recognize that substantial co-payments ultimately favor the poor in any event, because the larger the co-payment, the less likely that the poor will be able to afford it, and the more likely that the institution will decide to absorb the difference. Perhaps we must be prepared to live with that. But we cannot afford to assume the burden of caring for Medicare and Medicaid patients under cynical government restrictions. In other words, both institutions and the government must be responsive to community needs.

Finally, I believe prospective reimbursement will offer us protection from rapid and unpredictable changes in policy. We need to restore a stability to the delivery system which it has not enjoyed for several years.

A prospective arrangement that includes these features will enable us to preserve the quality of our care and equal access as well. It will lower costs and should lower the use of the system while nonetheless preserving teaching hospitals and their special contributions. It will effectively internalize competition without promoting destructive conflicts in the marketplace. The prospective approach will force improved management and the kind of tough decision-making that seems to be impossible under retrospective cost reimbursement where there are no incentives to hold down costs.

A totally free marketplace is the wrong idea at the wrong time for the American health-care system. In fact, I believe health care has become such

an essential service in American life that it ought better be viewed as a controlled resource than as a creature of laissez-faire. Health care needs prospective review and public oversight. I am well aware that this is almost precisely the opposite of the present system, under which some institutions have been able to reap substantial profits.

Let me finally say something about the role of the physician under a revised system of health-care delivery. It seems clear to me that the physician's life would be much easier under a system of prospective reimbursement than it would be in a free-market competition. It is true that the physician is in many ways a small businessman. But in most ways, I think, he is admirably unsuited to the competition of the marketplace. In any event, whichever way the country chooses to go, the doctor is certain to be pressed toward a more corporate form of medicine. With a probable surplus of physicians in this country at least through 1990, there will be more physicians competing for a share of the health-care dollar. If there is no long-term increasing use of health services, as was true from 1968 to 1976, consumer demand in 1990 will be for only 415,000 doctors, not the 600,000 we will have available.

Now, the policy choices we make will surely influence demand; and physician behavior, including a shorter work week or more time spent with each patient, can surely increase demand in subtle ways. But these considerations do not greatly change the basic forecast. Since 1970 the average medical practice income in most specialties has declined, and it is likely to continue to do so. The growing supply of physicians will adversely affect their ability to earn high incomes in private practice and in previously attractive communities.

The economic situation of the individual physician, especially the heavily indebted young physician emerging from medical school and residency training, is

likely to have a revolutionary effect on the delivery of health care and the modes of physician practice in the United States. Up to now, HMOs, other prepaid group practices, and salaried hospital positions have attracted only a minority of the profession. But every succeeding year will find more and more physicians happy with the relative security of such salaried jobs. And aggressive marketing tactics of institutions are likely to see the establishment of multi-specialty group practices with teams of private physicians and admitting ties to the hospitals that spawn them. These group practices will be designed to pick up the ambulatory surplus in the community and will place institutions in a highly competitive situation with physicians who already feel the pinch of a manpower surplus.

The big question is, what effect will all of this furious physician activity have upon health-care costs? The answer is likely to be one that again flies in the face of marketplace wisdom. That is, if past experience is any guide, the increasing supply of physicians is likely to increase total health-care expenditures by a substantial amount, perhaps 25 percent, according to Eli Ginzburg. Costs will also be influenced by the success of the new system in controlling and reducing hospital beds, because physicians enjoy certain income benefits from hospitalizing their patients.

The aim of a modified or restructured health-care system for Americans should not be to enact social Darwinism among our people. We recognize nagging cost problems built into the present system; but these are problems amenable to solution without destroying most of the benefits of the system. The Reagan administration has brought with it a sense of vigilance in the land over what some people regard as unwanted and unnecessary costs. The danger in our present situation is that this vigilance will produce a new breed of vigilantes who are ready to string up the social programs we have painfully constructed for the betterment of our

citizens over the past five decades. If this happens, the Reagan administration will create a social deficit in this country which will ultimately make its fiscal deficit look like petty cash. Future generations might face an unbearable burden of expense to put these programs and the country back together again.

The health-care industry needs to be a part of the national solution for health care. But we cannot accept the dismantling of an effective apparatus which serves most all our people. We can accept a solution that addresses social needs and provides a quality of care to which we can point with pride. Toward that kind of solution, we must be ready and willing to offer the best minds in our profession.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"REORGANIZING FOR OPERATING AND FINANCIAL FLEXIBILITY"

Presentation by J. D. Epstein

Now I know why there's a lawyer on the program today. Thank you, Karl. Usually when I walk into a hospital and the doctors find out there's a lawyer on the premises, people start disappearing. Fortunately, there are a lot of nonphysicians in the house, and so there's not much disappearance yet. I couldn't have asked for a better lead-in than what was given to me by Allen Hicks, Scott Parker, Karl Mangold and other people who have spoken to you. It is quite clear that the challenge is at your doorstep in the form of what are you going to do.

It's interesting to know that everyone is talking today about corporate reorganization, corporate restructuring, corporate structure, legal structures, etc. It's become almost a fad. In fact, a concern of mine is that many people look upon it as as a fad. I think you need to step back and take a look at this whole area of corporate structure, corporate organization, and realize it's not something new. We have been organizing and reorganizing and structuring corporations for as long as our law firm has been in existence, and before that my partner back in 1964 reorganized one of the largest Catholic organizations in the United States into a very viable organization which continues today constantly evolving.

I think that the bottom line in this whole presentation for you is basically that every hospital in the United States needs to undergo what I refer to loosely as an organizational assessment from a financial, operational, planning, yes, and legal perspective. I've got to have some fees in there. So it includes legal assessment. That does not mean, however, and I want to make this clear and clear as it can be; it does not mean that every hospital, every institution in this country should reorganize, should restructure to change its internal structure. There could be no better argument for vertical restructuring than that Karl Mangold has given to you this afternoon because he is going to be out there just as he says he is, and we know that. We've seen Karl. We've seen his work, and he is out there, and he is marketing the hell out of his services. There are many opportunities for people to compete with the Karl Mangolds of this world, and we'll talk about some of the competition as we go through the presentation.

The second thing is not only must you look at the hospital from an organizational assessment. Having heard Representative Gradison, as some of you know from Cincinnati, in a presentation before the Catholic Health Association, he challenged the members of that association by saying to them, each of you needs to stand back and look to see if you can continue to operate under the present and future environment as a tax exempt organization; a challenge to the

nonprofit industry of this country by someone who probably knows more about health care and understands more about health care than any member of Congress. That's a little frightening when you consider the House Ways and Means Committee is considering such things as in essence, eliminating tax exempt financing for hospitals. Especially since capital formation is going to be a major issue for the 1980's and, of course, for the future.

I'd like to quote to you a statement I made recently in an article concerning restructuring. "Is restructuring an illusion or a viable management strategy? If a hospital's management team is not strong, if it lacks a sound business plan or if the only reason for restructuring is to maximize third party reimbursement or some other short term goals, then trustees must resist the temptation to restructure." I think that's a message all of you must understand. There are tremendous amounts of pressure from all sorts of angles on hospitals today, pressures that we all have to relate to, pressures that we all see. Now, those pressures may force us into taking a look at our organizational structure, but some of those pressures should not dictate to you that you must restructure and must undergo some type of total management chaos in order to maximize reimbursement, minimize disallowance, etc.

I think the biggest problems the industry faces today are the various external pressures. As I see it, the hospitals and Blue Cross have to shoulder a lot of the blame for some of the pressures that are on the industry today. One of the problems you have to look at is that Blue Cross was organized to guarantee payments to hospitals. Hospitals organized Blue Cross. The hospital at that time was basically a single community provider that was in the business of providing institutional acute care. That was its purpose and its mission, and Blue Cross' payment structure was designed to pay for that institutional rendered care. Today that's not the hospital's only mission. It cannot be its only mission.

Because of the change in mission, institutions now have to look at how they're structured. Are they structured in the best way to be able to relate to its new mission.

You also have the external pressures that were not there in the 1940's and 50's and 60's. Local management control, whether it be by the board of trustees, administration whatever, is being eroded. Health planning is one example. Everyone says, well, health planning is going to be dead. It won't exist. I think that's both shortsighted and wrong. You're going to have health planning for a long time because most of the people in this room don't want to see it die. Health planning is one form of regulation that I think you can equate very clearly to the bad effects of airline deregulation. And if you think that airline deregulation was good for Braniff, I think you can see the same fate for many community hospitals if we simply do away with health planning in its entirety. Whether it be continued at state, local or federal level, I think you're going to see it continue. I think you're going to continue to have some type of "over the shoulder" review from the health planners. That has eroded local management's option; you no longer can simply say we need a new CAT scanner and buy it. We need new beds. We'll build them. We'll open a new service. It doesn't make any difference if the hospital across the street has it. That's all right. Our doctors want

it. We'll put it in. You can't do that any longer in most places. I don't think you should be able to do it.

Obviously, that's not the type of competition that reduces cost. So I think you're going to see health planning continue, and you're going to see further erosion of local management prerogatives. I think you're going to see more regulation, not less regulation; regardless of what we go into, I think that that's been the message that Dr. Buchanan has given you; that's the message we've received the last day and a half.

I think you're also going to have a continuing problem with ability to formulate charge structures. Now, those of you in the northeast have said, well, we've never had the ability to formulate charge structures. We can't remember when we had the ability to formulate charge structures. Dan Barker sitting down in Atlanta, Georgia formulates charge structures every day. He does have to give Blue Cross 60 days notice before he raises his charges but he formulates charge structures. Well, that may be changing also, even in Georgia. As Blue Cross, as the commercial insurers become more tired of the cost shifting--and you don't have to read too many Newsweek or Time advertisements by the HIAA to understand what they're talking about--that ability to shift costs is going to be going by the way.

Major cost payers as we know fail to reimburse the costs of the hospital, but they are reimbursing cost. And it is a safety net in Medicare, for the most part in hospital Medicaid reimbursement, and that is they're required to reimburse cost. Now, they can define cost, which they're constantly doing. They can limit cost. But there's still a safety net out there that they have to reimburse cost, however defined. Now, obviously there are some people in the room who favor the American Hospital Association proposal, and by no means am I against it, but I think everyone realizes it has little likelihood of success in this coming year. That is one of the things that the proposal does not maintain, that is that safety net of cost reimbursement. We're all gambling in a way. We're gambling in a way that prospective reimbursement will be a panacea, and we've heard people talk about that's what we all want prospective reimbursement.

I'm not so sure we all want prospective reimbursement. We all wanted a case mix system because we knew that our case mix would prove that our hospital does a better job than the hospital across the street. Everyone said, we've got to have the case mix. We all went out and argued that, if you'd use the case mix methodology, the 223 limits would produce for us higher cost. We wouldn't be over that cost cap if you used case mix methodology. It was considered a panacea for everybody. Well, it can't be a panacea for everybody.

I think we have to realize that no matter what the reimbursement system is going to be, it's not going to produce more than what we have today from the standpoint of real dollars. The government pie, as they're saying in Washington, is only so big, and all they're going to talk about is cutting it differently, just cutting that pie up in different sections. The cutting up of that pie is a tremendous pressure we're faced with. Whether it be reasonable cost or it be some type of prospective reimbursement, it's not going to be all your cost. It's not going to be all your expenses. It'll be something less than that.

One example of the tremendous pressures that Medicare-Medicaid reimbursement methodology does place on the hospital involves the allocation of overhead. Why are your costs \$126.00 a day in that emergency room? Why can't you compete with the Karl Mangolds? Because that emergency room happens to be located for all practical purposes in the most expensive building in the United States - a hospital. And it carries with it all the overhead that a hospital has. Now, you don't have to operate that emergency room in your hospital. It does not have to be on your campus. You can do the same kind of thing that Karl Mangold is doing. In fact most of you sitting in the room with large medical staffs, closed panels in most cases, with people who are used to being on a salary, could effectively compete across the street with EmergiCenter or MediCenter or whatever you want to call them.

You don't have to have that excessive overhead. You can cut \$50.00, \$60.00 right off the top of that \$126.00 when you take that emergency room off campus. Now, there are some potential problems. There are some licensure problems. There are some certification problems possibly. There are some CON problems, possibly. But it can be done. There are hospitals who are doing it. There's no reason why a hospital, and here's a pure form of the beginning of vertical diversification, can't compete in that type of situation. The proprietary chains are doing it.

Karl mentioned that Humana is opening up hundreds of same day centers, or Emergicenters, or bandaid centers, or whatever you want to call them. It's the same thing. And you're being provided incentives to do it because the 1981 reconciliation act included a provision that limits the amount a hospital will be reimbursed for nonemergency services in its emergency room to what it would have cost if that service was provided in a doctor's office. All of us had better take a look at that provision and see what the effect is going to be on a reimbursement of those services in our hospital setting.

The way that the Medicare and Medicaid programs and all your cost reimbursers allocate cost, you can do very little about that \$126.00. The reimbursement mechanism dictates how much cost must be allocated down to that emergency room so long as it's operated by the hospital, on the hospital premises, under hospital administration. You can't compete on a dollar for dollar basis. You cannot compete on a price basis with the Karl Mangolds for that service. No way, not in that setting. It can't be done, pure and simple.

Another issue, of course, with Medicare reimbursement and Medicaid reimbursement and all cost reimbursement is the effect they have on your attempt to sell services to other institutions, non-institutions, to physicians, to group practice, whatever. The effect of your institution selling services under its Medicare-Medicaid cost and Blue Cross cost payment, is that for every dollar you receive from selling services, the third party payers take their percentage out of it because that's the way the cost reimbursement programs work. Therefore, attempts to become more cost efficient and provide service to others oftentimes end up in less reimbursement.

Karl asserts that hospitals don't want to reduce their costs because the board of trustees believe its their fiduciary obligation to maximize these costs because you're trying to rip off the federal treasury. Well, I come at it from a little different, I think, perception than that. One, the bottom line

fiduciary obligation, in my opinion, of board trustees and administration is to produce the best quality care to the community at the lowest possible net out of pocket price. How do we produce as an institution the best quality care to the community at the lowest net out of pocket cost? Just as the Supreme Court ruled many, many years ago that it was the duty of the taxpayer to minimize, to legally minimize what he pays in taxes, it is the duty of hospital administrators, a hospital CEO, the Board of trustees of a hospital to maximize legally its reimbursement from all payer sources. If you don't, all you're doing is further shifting the cost from the payers you don't maximize from to the other payers, especially from the cost payers to the charge payers.

Senator Durenberger stated that we realize we're shifting costs, but we have an obligation to cut the federal budget, and that's what we're all about. We recognize that when we cut the federal budget and we pay you less, someone else has to pay it, whether it be Blue Cross, the commercial insurers, the community; unfortunately in the scheme of things today it doesn't make any difference. If they cut \$5 billion out of Medicare and Medicaid or Medicare reimbursement alone, they know someone else has to pay that tab. They've been told that enough now. HIAA's been up on the Hill. Blue Cross has been up on the Hill. They're telling them what's happening, but Congress has one thought in mind. That's cutting the federal budget. But what's the effect on the other payers?

You're seeing it in Blue Cross in the situation where cost shifting--and in my estimation also some poor management--is leading some Blue Cross plans down the road to financial disaster. How long can Blue Cross of Texas incur \$45 million in loss in one year, \$30 million in loss the next year. That can't go on too long. There's no bottomless pit in Blue Cross any more than there is for anybody else. They're feeling it, and they're going to start putting pressure on the hospitals to contain costs, control costs. I think what you're going to see is state rate setting programs pushed by Blue Cross plan as a way of trying to contain they're own costs. I think you'll also see it being pushed probably by some of the commercial insurers as well.

I think you're going to see more and more proposals like Senate bill 136 in the Ohio legislature. Senate Bill 136 went to the issue of cost shifting, not so much between Medicare and Medicaid to the commercials but from Blue Cross to the commercials. As most of you in Ohio know, Blue Cross has been on a cost reimbursement system for years in the state of Ohio, whereas the commercial insurers pay the charge rate. The commercial insurers got introduced in the legislature a bill which says basically that no one should be required to pay more than the lowest nongovernment payer. In essence if Blue Cross gets a discount, the Prudential, Metropolitan, etc. want the same discount. Those types of pressures are continuing and I think rate setting by the states is going to be an issue which is going to continue hot and heavy.

The government has tried numerous federal incentives to get states to start rate setting and I think that will continue. I think you will see more pressures imposed by the Internal Revenue Service. In 1979 we were told that the IRS transferred some 150 employees from the fringe benefit section to the tax exempt section. We have seen in our own practice a tenfold increase in IRS audits, looking for things like unrelated business income and inurement.

We have just seen for the first time, the Internal Revenue Service issue a notice of termination of tax exempt status involving a tax exempt bond issue. If you don't think the ramifications of that aren't overwhelming, you're sadly mistaken. Can you imagine what the effect is going to be on a bond issue that's been outstanding for ten years and IRS determines that that bond issue is not tax exempt? The pressure from the IRS as more and more hospitals get involved in more and more types of activities under single, current corporate structure will continue. With the new look by the IRS at the tax exempt industry, it can only mean more and more investigations and more and more audits.

We still are seeing some of the big malpractice settlements. The ability to shelter non-health care assets from those megabuck litigation is another issue, another pressure point. Obviously some other socioeconomic factors have also emerged that have caused the pressures on this industry and the way we operate and really questions and threatens the viability of a single entity health care facility.

Congress talks about competition. We've heard about competition today, and I think the one comment that was absolutely on point is that we've had competition for a long time: competition for doctors, competition for patients, competition for that dollar. That's not what the government is talking about. That's not producing lower cost for the government payer.

I don't know if anyone is here from Memphis, Tennessee, but if you want to see competition in its purest example, go down to Memphis, Tennessee and see the competition between Baptist Hospital and Methodist Hospital. Fortunately, there's no gunfire. It's not Northern Ireland, but the Baptists and the Methodists are really at it. That's the type of competition we're talking about. They're trying to assure their market share. They're making sure they don't lose that market share, but, in fact, increase that market share. Each of the hospitals has gone out and developed affiliate organizations, purchased organizations, managed corporations, managed hospitals around the mid-South. They both have enlarged their mission.

But, that's the type of competition we're already having, the competition for patient referral. We're also seeing these hospitals go out and compete by setting up primary care clinics in small towns in Mississippi where a hospital is not needed. They would never have the census to support a small community hospital. There is a need for a primary care clinic out there with physicians on salary or whatever the basis of compensation is.

When the patient needs referral to the hospital, where are they going to refer them? If it's Methodist that is opening that primary care clinic, staffing it with Methodist employees, then there's a guaranteed referral pattern.

It doesn't help to go out and buy a hospital where a group of doctors have been referring patients to the other hospital for 30 years and think you're going to change referral patterns overnight. I think you're kidding yourself. You may in the future change those referral patterns as you start maybe putting people down there, guaranteeing income, guaranteeing salary, putting incentives down there. Yes, you may increase your referral patterns to the tertiary care center that way, but you're not going to do it overnight simply

by buying a hospital when those referral patterns have been in existence for years.

Shifting of population centers is another pressure point that sits heavily on hospitals today. If you're in a downtown location with the patient population moving away from you, how do you compete? How do you keep those patients? Henry Ford came up with the answer with their clinics. They've gone out and established substantial clinic operations in the outlying communities, and they're still able to feed that downtown tertiary care center.

Physicians--I couldn't ask for a better lead-in than Karl gave me--are going to be the competition. In some cases, they will go out and set up competing nonhospital environment types of ventures. That's another pressure.

And finally business coalitions and the advent of a brand new alphabet soup on the horizon called PPO's. How many people in the room have heard the new PPO alphabet? There's one or two. They may either be from Denver or Minneapolis or Los Angeles. Did I hit one of you or any of you? Yes. It's called Preferred Provider Organization, and they may well be the thing of the future. They probably, at this point in time, violate every law that is known to man in their operation from insurance to corporate medical practice to antitrust and a few other things. But, if they work, there's probably a way around those laws. Of course, that always keeps us lawyers busy!

Those are the various pressures. Those are the things one must look at, things one must contend with. I think that they all boil down to forcing every hospital to stand back and look at itself.

I'd like to spend a couple of minutes talking about after you've done an organizational assessment. I think the key is here, and it is not your lawyer, not your CPA. Lawyers can put all kinds of nice boxes on a chart, all kinds of nice little legal structures and legal entities and legal fictions together, but they don't mean a damn thing if you don't have a strategy, a market plan.

Marketing really is probably the most important aspect of knowing where you're going in a restructuring. You've got to have a plan. You've got to know where you're going. You have to take a look where you are, where you're going and how you're going to get there. And the one element after marketing that is second most important is your financial feasibility. Is what you're going to do going to make money? Is it going to be profitable? There's no sense going into a half a dozen ventures and forming ten corporations if they're all going to lose money. If the financial feasibility is not there, then you better take another look at what you propose to do.

Once you determine that your marketing is there, that the financial feasibility is there, and that you can do it legally, you've got to sell it to a board of trustees. It is a sales job in most cases because there is nothing more political than working with a teaching hospital environment. It is going to be one tough sale to convince them that your hospital needs to be restructured. And I think what's going to be the toughest thing for anyone is the politics of developing a plan for that board of trustees. Educating and selling the idea that the best thing for this institution is some form of corporate restructuring that's going to involve a loss of some control in all probability will be

difficult. Whether it's actual control or perceived control does not make any difference. Not to a board of trustees it doesn't, because perceived control is just as important to them as actual control is.

You must develop a good institutional plan. You must be able to convince that board that it's necessary because of the financial, the strategic marketing, the legal and all of the other ramifications that this has to be done. That's the toughest part of any corporate restructuring. The legal part is the easiest. In order to get to that place, you have got to set up a task force to select a group of people from that board of trustees who are going to be your leaders in making it work.

And if you know people on the board you think are going to be against it, you better get them in the game early. You better get them in the game at the very beginning and let them start espousing their concerns, expressing themselves, playing the devil's advocate right up front, so you know where the chips are going to fall when it comes time for that full board to vote on how you're going to handle that corporate restructuring.

As you go into it from a legal standpoint, there is a tremendous amount of legal work that has to be done by somebody in or outside the organization. All documents of indebtedness must be reviewed, everything that concerns such things as mortgages, bond indentures, security agreements, government obligations. All of them have to be reviewed to see if legally you can do what you think you want to do.

Of course, if you're dealing with the university, the state charter must be reviewed. Can you set up a separate management company? Can you set up a parent holding company if that's what you're doing? Can you set up a sister organization? Can you set up a subsidiary? Can it be a for-profit subsidiary? What are the legal restrictions in that situation?

Analysis of all third party payment contracts and cost reports must be done. As you go into various places in this country people will tell you, yes, if you can maximize reimbursement. Well, you may maximize Medicare reimbursement, but you may do one hell of a job minimizing Blue Cross reimbursement, or vice versa.

And there are some functions that once taken out of the hospital won't be reimbursed by anybody. You'll get no reimbursement for it because it's not in a hospital. Even though you're losing money on it, it was better doing that than not having any reimbursement or coverage.

A good example is alcohol detox. How many of you are aware of the fact that Medicare will not cover alcohol detox provided in a free-standing facility? It won't. For a period of four months they would, because in October the 1980 Reconciliation Act or Omnibus Act -- I get the two mixed up -- passed a provision which provided coverage. In April of the next year, '81, they repealed it. So, if you plan to have a free standing alcohol unit or drug abuse unit, you won't get Medicare or Medicaid reimbursement.

Real property audit -- what does a hospital own? What are its assets? What assets does it own and have restrictions on that can't be transferred? What

are the restrictions on the hospital caused by the articles of incorporation and bylaws? What can or can it not do? Does it need to amend the articles? How does it amend the articles? Who's the sponsoring body? What is their control?

What about the tax returns? I think most of you would be very surprised once you have someone do an analysis of your tax returns and they find out the types of activities you're engaged in that probably are not being reported. There's probably not a hospital in this country that's operating a single entity that a good tax attorney cannot walk into and find unrelated business income that's not being reported. And if it gets to be a substantial amount, you could have a serious problem.

Same thing from an ad valorem tax standpoint. Hospitals are probably performing functions that from an ad valorem tax exempt standpoint are not tax exempt, especially if you're in the State of Texas.

All the above are parts of an organization assessment. Once you have done that assessment, then there has to be development of a preliminary pro forma of what is going to be done from a financial, legal and planning standpoint.

And a reconciliation, at this point in time, of what you may propose to the mission and the plan of the facility. So many administrators and executive staff get into a position where they forget the mission they're dealing with. Boards of trustees don't forget the mission typically. They know what the mission of the institution is, and most times they'll bring you right down to earth with a simple question, how would you propose to relate to the mission of this institution? A very real issue for most nonprofit tax exempt boards of trustees.

Once you develop an organizational plan, once you develop what you want to do, then you need to develop a very carefully detailed, step by step implementation plan of how you're going to get to where you need to be from an organizational standpoint, the various tax rulings that have to be filed for, the various asset transfers that are going to be taken care of, how do you educate and get the requisite approval from each of the bodies, the boards involved, creating and qualifying entities, developing really the sound business reason why you're doing this corporate restructuring.

I'd like to leave you with a couple of thoughts on the whole gamut of restructuring, and then we'll close off this thing. One point is that you've got to have a strong management team. The breadth and depth of a management team is of paramount importance because nothing will ruin a corporate structuring than a lack of management depth.

And I have seen in the last ten, 15 years a number of situations where people went beyond their management depth and paid the price. I think a key here is you need to establish an organizational structure that will give you the flexibility in the long run to become part of, and I really mean this, part of a system whether you are the leader of the system or a member of the system. As Allen Hicks and Scott Parker talked about today, hospitals are going to survive and they're going to be successful, but they've got to be part of a system. You need that flexibility to either be the leader of that system

or to be part of that system to reap the benefits that I think Allen Hicks espoused this morning. I think that's the key to corporate restructuring, to give you the flexible financial and operational ability to become part of a system and to deal with the pressures we talked about early on.

Management, good management, flexibility of operation are the keys.

I thank you.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"MARKETING THE TEACHING HOSPITAL'S PRODUCT"

Presentation by JEFF GOLDSMITH, PhD

Please forgive the hoarseness of my voice this morning. I was persuaded that it was a product of a spring cold until I went to the ENT specialist in our institution who told me that it was really my voice changing.

Now, for those of you that recall Dr. Munson's remarks yesterday about the young fellow who has to go and tell the physicians that they're not returning their phone calls to M.D.'s, well, I'm that person in our institution and that's the kind of medical care you get if you're the bearer of bad news.

I want to thank Spike Foreman very much for the opportunity to address you. It's an honor for me. I also want to thank him for putting me after Dr. Mangold, because as I customarily do in giving this talk, I try to absolve my superiors of responsibility for what I'm about to say and explain that it's only a persistent strain of staff advice that they're getting and that I intend to be deliberately provocative. But after Dr. Mangold's performance, that's going to be very difficult for me to do, and I don't think a disclaimer will be necessary.

What I'm going to do this morning is three things. I'm going to give you my sense of the competitive environment within which we operate and of some of the forces, particularly in the reimbursement system, that are driving the competitive market for health services. I intend to discuss some of the strengths and weaknesses that I believe our institutions have in confronting that market, and then discuss some of the strategies that I believe we're going to want to be experimenting with to strengthen our competitive position.

We heard a lot of discussion about the reimbursement system in the last day and a half. I don't think the recent annual 19% increase in hospital costs strained merely public budgets. It certainly had a major impact in precipitating or worsening fiscal crises in many of the major states around the country, and added to the pressure that Medicare puts on the federal budget.

But it also significantly strained the private health insurance sector. Private health insurers, including Blue Cross (although I recognize that they are not entirely insurers), lost approximately half a billion, and the commercial insurers, those wonderful individuals that pay us

(most of us anyway) billed charges, lost \$1.5 billion writing group health insurance.

In addition to being a dreadful signal to the Administration and Congress of this industry's lack of responsiveness to the imperative of bringing down inflation, the most recent sharp increases in hospital costs have put an enormous strain on the entire system for paying for health care in this country.

Prior to 1980 the reimbursement system was in many ways quite accommodating to our institutions and to the physicians that practiced in them. They paid our physicians more or less carte blanche on a piecework basis for the services that they rendered to their patients. They paid our institutions more or less our costs incurred for treating patients as the physicians dictated.

I think what is happening faster than any of us realize is that set of ground rules is coming unglued under increasing economic pressure. And, the sleeping giant of medical purchasing power which has been neutralized by reimbursement ground rules that have prevailed in the past is being awakened by the nation's economic crisis.

Every payor is going to be taking short-term steps in a sort of Hobbesian process to cut their losses, to try and limit the outflow of funds or their liability under health insurance, in a way that will make many of us yearn for a set of rules.

Part of the problem with the process that's taking place is that there are no rules. And the various actors in the system are going to be behaving increasingly in terms of narrow self-interest and less in terms of the impact of their particular set of actions on the rest of the health care system. I'm thinking particularly here about Medicaid.

The best way of summarizing what I see happening to the reimbursement system is that we're moving away from a system of cost-based reimbursement, and towards a system of brokered care, where increasingly those individuals who pay for care will be dictating the terms, conditions and prices within which services will be rendered to populations they cover.

Let us review briefly who these brokers are and talk about their strategies. First and foremost, we have the nation's governors. While most of the organized hospital industry was lobbying last year on Capitol Hill to prevent significant changes in Medicare reimbursement, the nation's governors succeeded in convincing Congress that they needed "more flexibility" in administering the Medicaid program.

What Congress gave them was the ability to set Medicaid prices regardless of cost, but even more significantly the ability to reorganize the system of care within which Medicaid services are delivered to exclude high cost providers. And, there we must read us from the program. As that great humanitarian governor James R. Thompson of Illinois said in implementing those new powers, "Why provide Cadillac care for the poor when Chevrolet care will do?"

In Illinois this year, hospital care is anticipated to be reimbursed at approximately 70¢ on the dollar, relative to cost, and major rumblings are being made about putting significant chunks of that business out to bid, with the possibility that we may be deprived not merely of the marginal Medicaid patient, but significant chunks of Medicaid utilization in the process.

Private industry has lost patience with the nation's third party reimbursement system. To private industry benefits managers and corporate finance chiefs, third party insurance including Blue Cross is viewed as doing little more than standing and waving at health care costs. For those of you that are not basketball fans, standing and waving is the defense that the Chicago Bulls employ when they play the Boston Celtics. That is, you put your great big guys in the lane and they wave at Tiny Archibald as he goes by to the basket.

In the last five years, there has been almost a tripling in the number of business firms in this country that have gone self-insured, not only for workman's compensation but for private insurance and health insurance for their employees as well. And I'm reliably informed by my friend Nancy Kane at the Harvard School of Public Health, that almost half of the nation's large firms are now self insured.

Increasingly, our organizations and the rest of the health care system are going to be dealing directly with the private industry in arranging care for their patients. Why should this concern us? Well, because those group insurance plans which industry is now bypassing have been the vehicle by which we have funded the increasing deficits from rendering service to government under-insured or non-insured patients.

It's important to realize that it is not merely the Medicaid patient who is going to lose freedom of choice of provider, particularly hospital provider. Increasingly it will be the nation's covered work force as well. Institutions like ours must position themselves for a world in which most of the nation's large employers will be managing their own health benefits directly, even, I suspect, a significant number of our own institutions.

Private group insurance firms such as Prudential and Aetna are not reacting passively to this obvious threat to their core market. They are beginning to execute in the Chicago area and elsewhere what are known as preferred provider agreements with specific organizations in their market. Covered workers under the Aetna Choice Plan, for example, would continue to see their private physician. But when they need specialty care, they would be compelled to go to a designated hospital that is contracted with Aetna to render that specialty care or else pay a significant amount out of pocket.

Aetna is attempting to pass on the to the corporation the savings from contracting with responsible conservative institutions that have strong utilization review programs. I suspect hospitals will eventually be willing to discount their services to Aetna in exchange for large blocks of private insured business. This preferred

provider concept I believe will eventually sweep the private side of the health care industry.

In the process, I believe it will devastate Blue Cross, which is organized in a way that makes them constitutionally - by the very way they're organized - incapable of selecting out only a few hospitals in a particular market to render care to Blue Cross patients.

The half a billion dollar loss that Blue Cross systems across the country incurred last year is not, as many of its leadership believe, a transitory phenomenon. The group insurance market is shrinking rapidly, and it is shrinking most rapidly in the Blue Cross end of the market where many hospitals of course have been significant participants.

The Medicare situation remains fluid. The Administration as heard earlier has proposed, as much in expediency as from creative thinking, a two percent deduction from cost. The Federation of American Hospitals has been pushing forward a Medicare proposal that would basically turn the program into an indemnity program and cap the rates in a particular area and permit institutions like ours to bill the patients for the difference between our costs and the rate, of course converting a significant fraction of our current Medicare revenues into accounts receivable to be collected from the elderly patient living on a fixed income.

But a very interesting wrinkle in the AHA proposal that floated about a month ago in Washington was that after a couple of years of this prospectively capped rate, Medicare business in a particular area could be put out to bid. And, if a significant percentage of hospitals set the Medicare price in a particular area and your hospital was not one that met the price, you would become a "non-assigned" Medicare provider, and wait while everyone else gets paid for Medicare services.

Finally, we have the health maintenance organization. Health maintenance organizations are the classic brokering intermediary for those individuals that are enrolled in prepaid plans. The idea is that if an HMO enrollment reaches a particular level in a market, HMO's will have enough market power to direct their patients to institutions that are willing to discount their services.

I think that this discounting phenomenon has yet to be documented, in part because HMO enrollment is still not a majority of the enrollment in any particular market in the country. But I think it is reasonable to anticipate as HMO's grow and achieve market power, that they will use that power to try and hold down hospital costs.

I think the sum total of these developments is that providers of care are going to be confronted with a very different economic environment than they're facing. And it isn't merely going to be the government programs that put pressure on us.

And if we are not organized to get involved in that process of brokering and have the financial data and the ability to discount our services

and to make arrangements with the people that pay for care in a particular area, we could be deprived of large blocks of business, particularly paying patient business.

Now, where's the good news in all of this? Well, the good news is that we're not alone. I don't know how good that news is. The hospital industry as a whole is vulnerable to a tightening of the market for health services and to the emergence of price as an increasingly important factor in the purchase of services.

The fact that we're not going to have pro-competitive legislation coming out of the Administration or Congress is little comfort to me, because I think it's going to happen anyway. The kinds of developments that are taking place are going to happen whether Congress enacts some kind of sweeping reform or not.

I've compared the hospital to the urban department store, which is facing murderous competition from alternative retailing modes, from boutiques and specialty stores, from discount houses, drugstore chains, regional shopping malls, direct mail and the like. The hospital is facing similar competition from alternative modes of delivering health care on which the hospital formerly had a monopoly.

You heard from one of the individuals yesterday who's in the process of aggressive development of alternatives to our emergency room. The most sobering thing about dealing with Dr. Mangold is that at the point where we all begin to realize that he's taken a significant fraction of our markets, we're going to have to go out and negotiate for his specialty referrals. That will be the crowning glory of his career because each one of those little facilities generates somewhere between 75 and 150 specialty referrals a month. And if he doesn't like you, as one of his colleagues in the Chicago area has done, he'll simply ring your facility with freestanding emergency centers and send all those specialty referrals to your competition. It's not a very appetizing prospect. Even before the economic tightening that we have been experiencing in the last several years, the market for hospital services has ceased to be a growth market. And the reason why this is important is that strategies that one pursues in a maturing market are very different indeed from strategies that one pursues in a market where one can make strategic errors and be bailed out by the growth.

I want to show you some of the data that substantiates the statement that it's no longer a growth market for hospitals. The first graphic shows the growth in patient day volume of the nation's community hospitals during the postwar period.

As you can see, from 1946 to 1971, the volume of patient days rendered in the nation's community hospitals roughly double. But from 1970 to 1981 they increased only by about another 15%. The comparison of the rates of growth becomes even more vivid in the following line graph which shows the relationship between inflation, hospital patient day and room costs, in five year averages of annual percentage increases in hospital costs. Patient days grew by about 3.5% a year in the nation's community hospitals in the ten years prior to Medicaid and Medicare. In the five years after Medicaid and Medicare, interestingly enough, they grew at a less rapid rate. Costs went up like crazy, but the rate of increase in hospitals actually declined. And then during the 1970's the rate of growth dropped off to only about 40% of the rate of growth in patient day volume in the previous 15 years.

Now, if one looks behind these data at the per capita rates of growth of use of hospital services, one sees an even more interesting trend.

As you can see, patient day use rates per thousand population peaked in 1975 at 1254.9 days of care and actually declined in the five subsequent years. For those that are looking to the elderly population using an increasing number of hospital services, I would point to the use rates of the 45 to 54 age group, the people that are going to become the nation's elderly in the next 15 years.

Their consumption of hospital services dropped by 8% from 1975 to 1980. And in the postwar baby boom group, decline in per capita consumption of hospital services was even sharper, almost 11%. For those of you that have any lingering doubts that the Medicare program is going to have to be cut, ask yourself the following question: How long do you think the federal government is going to pay for 4.3 days of acute care hospitalization for every elderly person in this country? That is the meaning of that righthand bottom statistic we rate for the elderly for 1980. Medicare's policy dilemma is in a humane and responsible way to figure out how to bring that 4.3 days down to a manageable level by substituting where possible alternative lower cost aftercare services.

Now the interesting thing about these trends is that hospital patient day growth was leveling off and hospital per capita consumption of services was declining during a period when the reimbursement system was still operating flat out with cost increasing incentives which gave us our average increment of revenue for our marginal cost, and where physicians were paid on a piecework basis for doing more medical services. Why then was hospital use leveling off in the country as a whole and declining on a per capita basis?

Well, no one really knows the answer. But I have a theory. During the 1970's, there was very rapid growth in three sectors that represent alternatives to using the hospital: out of hospital ambulatory services, including ambulatory surgery and the freestanding emergency services that you've heard so pungently described yesterday by Dr. Mangold, after-care services for the nation's elderly, and alternative delivery systems such as the HMO.

As Medicare struggles with the problem of how to put ten pounds worth of sand into a five-pound bag, their principal strategy is to force us into moving the chronically ill and impaired population out of inpatient care and into a variety of cost-effective responsible alternatives to using the hospital.

The HMO remains controversial as a financing and delivery system, but I believe after examining the evidence that HMO growth in a particular market reduces the volume of inpatient days of care consumed in that market. I don't believe that HMO's are merely cream skimmers. I think that they do have a major impact in reducing patient-day consumption. While there are only about ten million people enrolled in HMO's at this point in the country, I think. HMO enrollment will continue to grow rapidly and will probably more than double by the end of the decade.

What is the meaning of these trends for our institutions? Well, because we are on the high-cost end of the hospital market, particularly the market for routine hospital services, we are vulnerable not only to the substitution of these alternative services for hospital care and to the increased pressure from brokers, but also to the loss of significant amounts of routine care to community hospital competitors that are both less expensive than we are and better able to position themselves in the brokering process discussed earlier.

We are facing a market where our competitors, both hospital competitors and physicians are going to be taking risks. They're going to be organizing their care and services and reaching out into the community to take away our business. If we don't have a strategy for dealing with this competition, we're going to be terribly vulnerable to the loss of significant amounts of business. And this is where marketing comes in.

Marketing is poorly understood in our field and elsewhere. I was interviewed in a recent radio broadcast by a woman from New York City who called me up to find out why hospitals were doing things like advertising on the radio and offering Mediterranean cruises for patients that checked in on weekends and that sort of thing.

I was trying to explain to her that marketing was a lot broader than mere promotion, that it involved doing research, understanding what people needed and the reaching out to provide them with what they needed. And I thought I had her convinced, until she went on the air and introduced me as follows, "Plying their patients with candlelight suppers and Mediterranean cruises, hospitals will do just about anything to get you into bed these days, won't they Dr. Goldsmith?"

Unfortunately, that public reception isn't all that far off the mark. Marketing is perceived by many of our medical staff and boards and by many of the people in the community as self-serving efforts to fill our empty beds.

Well, that isn't marketing, it's selling. An important part of marketing is realizing that people may not need our empty beds. And if we don't organize ourselves in a way to provide the services that people do need, whether they involve bringing them into hospital or not, we're going to be deprived of their business by aggressive entrepreneurial types like Dr. Mangold.

Probably the foremost exponent of the marketing concept was Peter Drucker. Peter Drucker wrote 30 years ago that organizations which define their business in self-serving terms are ultimately doomed to failure. Marketing organizations begin by trying to understand not their own needs but what other people need. Then, consistent with their goals and mission, they organize to deliver what people need.

In an operational sense, marketing and strategic planning are flip sides of the same process. Strategic planning involves making the intelligent choices about how an organization ought to deploy its resources in the market. Marketing involves implementing those choices. When Dr. Mangold plays the little tape recording of advertising for his EmergiCenters, that's not marketing. Marketing is putting those services out in the community in the first place. The radio advertisement was simply a way of alerting people to the fact that they are there.

Of course, you don't do any of that until you've identified the need which becomes evident in the course of auditing empirically the market and its needs. I think it's going to be a very wrenching process trying to market our institutions' services. We're going to have to put aside the inevitable flag waving and and self-congratulatory ethos that pervades many institutional planning exercises and in an honest and sincere and empirical way, try to understand what people outside the organization in our communities and regions need. Marketing begins outside the organization. In assessing the battle readiness of our institutions for combat in the competitive market we've discussed, the first step is to assess the strengths and weaknesses of our institutions. Let's start with the weaknesses from the marketing standpoint, some of which are generic and some which are less exhibited at some of our institutions than in others.

First of all, it is not obvious who is in charge at many of our institutions. We heard much about this problem yesterday. Our institutions are bewilderingly complicated matrices of authority and administrative reporting relationships, built around a medical "participatory democracy".

There is the most profound difference between our organizations and corporations. Corporations have strategies, at least the successful ones; democracies don't have strategies. They tend to pursue courses of action that represent the least perturbing common denominator of conflicting institutional interests.

The least perturbing common denominator of conflicting political interests may not move the institution far enough off its prior

course to enable it to adjust for rapidly changing markets. It's very difficult to formulate a strategy, let alone to implement it, where there are 300 or 400 "chief executives".

Second, it is not obvious what business we are in. We have multiple products, several of which are complex to articulate let alone to produce. In many of our institutions, patient care is almost epiphenomenal to the product considered truly important by our clinical staffs, research and teaching.

Because of the predominance and influence of professional and scientific peer cultures in our institutions, some of our medical staffs have come to resemble loose confederations of local chapters of national specialty societies coincidentally housed in the same buildings.

The relatively low estate of clinical medicine in some of our institutions is not lost on the patient or referring physician who already have a compelling economic reason to look elsewhere.

Third, in an increasingly cost-conscious environment, the costs in our institutions are out of sight.

For hyperspecialty care for mortal illness, our high costs are one thing. People will probably continue to pay them willingly, gratefully. We are able to solve problems that no one else can solve. But for routine care, those costs are quite another. We are pricing ourselves out of that marginal market for routine services that will make or break our institutions.

I would like to believe that a portion of the difference between our costs and the costs of a smaller community hospital is a product of a societal contribution about which John Colloton has written and spoken so eloquently.

I think there is also a component of that difference in costs that is attributable to inadequate information and control systems in our institutions and to a custom tailoring of the institution's bed allocations and support services to the idiosyncratic needs of powerful clinical chiefs and their colleagues.

I'm going to take a social scientist's chance here and ask you how many of your institutions give off signs that they're full -- admissions being bumped, queuing for elective surgery at 82% occupancy. I bet there are tens, in fact, hundreds of millions of dollars that I strongly suspect our institutions could be earning if we made more efficient use of the beds and services that exist in our institutions. There is an inevitable degree of complexity in bed assignments in a hyperspecialty hospital. We have 82 subspecialty clinics and services at the University of Chicago. But, the compartmentalization of beds and resources is a major problem because it causes our entrepreneurial specialists to be potbound and to not be able to grow as the market for their services grows.

Fourth, many of us are burdened with archaic delivery systems and bad locations. Many of us are practicing most of our medicine in highly centralized older institutions that have grown by wings and chairmen over a period of decades and we are employing modes of delivering services, particularly outpatient services, that are simply obsolete.

There is great resistance among our faculty to geographical and programmatic diversity. Many of our clinical faculty would have us arrange their lives so that they can teach, practice and do research within 50 feet of their offices. And the facilities that have grown up as the result of adhering to that preference are not going to be adequately distributed in the market to protect ourselves.

Fifth, the point that Dr. Mangold made yesterday: There is a lack of focus on the consumer, even more than in the typical hospital. The patient in many of our institutions is little more than a breathing brick, to use Odin Anderson's favorite metaphor. The lack of attention to the amenities of care is going to be a significant barrier to our competing effectively.

Having talked a little bit about the weaknesses, what are some of the strengths? Well, first of all we are and will remain the cutting edge against medical science's battle against intractable illness, against the menacing cripples and killers that have outflanked conventional medical practice -- sarcoma, multiple sclerosis, Reyes syndrome, congenital heart disease. We have a monopoly on these tough and expensive problems. And as long as people will not surrender meekly to intractable illness, they will continue to come to us.

But we're also the health care system's safety net. Trauma and critical care, to be certain, are part of our mission. But we also handle an enormous number of botched and mismanaged cases, cases that should have been surrendered to specialists far earlier in their management but for a variety of reasons continued to be in the care of physicians that were practicing medicine over their heads.

We welcome these cases. They're good teaching cases and they're part of the reason why we have tertiary hospitals. But we also ought to remember, we are in the process of serving and helping the community physician. We do know their limits. However much they may complain about us, we've saved them billions of dollars of malpractice problems and time and difficulty with their patients.

We are also the source of greatest certainty in the resolution of routine potentially open-ended medical problems. We are in many cases the final diagnostic authority. We're not just tertiary institutions. Many patients come to us and are willing to pay our higher costs for the high quality of technical medicine that we practice and the additional 5-10% of certainty that we correctly diagnosed the problem and arrested its progress.

This market is very similar to the market for BMW's. Not everyone is going to be able to buy a BMW in the market that we're headed into.

But conversely, people aren't going to pay BMW prices for Chevrolet quality service. At the University of Chicago, our consumer surveys establish that teaching hospitals are preferred by upper bracket consumers because of the high quality of technical medicine we are perceived to render.

Fourth, our institutions are prestigious, both as medical and as social institutions. Our boards are often the pinnacle of the social elite in our community, and our staff and academic appointments are prized by physicians in the community.

While we have exploited this social power for fundraising, we have not yet begun to examine its usefulness in enhancing our market position and insuring us control over the flow of patients to us. I look to John Colloton at Iowa for an example of how much can be done when that power is appropriately exercised.

Finally, we've trained virtually all of the nation's physicians. We have some ties to our alumni. Some of them are troubled ties. But some of them are ties that have simply not been maintained or developed. The development of strong regional referral systems is based in many cases on retaining ties to people that have trained in our institutions in a systematic way.

Having discussed these strengths and weaknesses, what can we do as institutions to position ourselves in the competitive market that we're moving into? Well, first of all, it seems to me that we're going to need the organizational flexibility to engage in a wholehearted way in the brokering process to keep our share of the market. And, we're also going to need the freedom to be able to launch new ventures that maybe don't make sense in terms of narrowly defined academic priorities but that make sense in terms of development and organization of a system of health care.

We are going to have to create action arms for our institutions that free its chief executive officers and planners from the agonizing, multilateral group consensus mode of decision making that is characteristic in many of our institutions' governance for the last twenty to 25 years.

We need freedom not merely from the internal governance struggles that were discussed yesterday, but from some of the relationships to overseeing university administrators, presidents, boards, legislators and the like. There are successful precedents for the creation of these action arms in what many universities, including my own, did in the 1950's to reverse the declines in the neighborhoods around their institutions.

There are emerging models of this action arm concept at the George Washington University, where Ron Kaufman is creating a for-profit subsidiary of the Medical Center to sell management services to other hospitals in the region and to develop freestanding ambulatory facilities. As well, a major teaching hospital in the Midwest has

developed a for-profit subsidiary to place its residents in practice in the community and to render practice management services to them once they've been established.

These are the kinds of things that we're going to have to have the organizational flexibility and freedom to engage in. Another example of corporate structure that I think we're going to be looking at increasingly is the preferred provider organization.

It would be foolish for our institutions to wait until Aetna comes to us and says, "You give us a discount or you arrange to take our patients elsewhere." Teaching hospitals, notably the Presbyterian/St. Luke's Hospital of Denver, have developed preferred provider organizations that represent the physicians on the medical staff at their institutions. And they're going out to self-insured employers, before those employers come to them, and saying, "Gentlemen, if you will send your patients to us, we'll give you a discount. And if you pass on a portion of that discount to your employees, they can use our services without any first-dollar costs." The preferred provider concept is the most powerful marketing tool that we have available to us to organize the flow of patients into our systems.

We have talked a little bit in this setting and elsewhere about downsizing. There's a strategic opportunity that is awaiting us in this process. Some of our institutions, and I know our own, are responding to economic pressures from Medicaid by beginning to reduce our graduate medical education program size.

When Rogers and Blendon told us five years ago that we were putting ourselves out of business by training the large number of super specialists that we have been training, many of our deans and hospital administrators responded a lot like people responded to the Surgeon General's report on smoking and its linkage to lung cancer. They said, "Gee, we are killing ourselves," and continued to do the very same thing.

In downsizing, one of the things that we ought to consider is whether or not to reduce the number of subspecialists that we are training as a proportion of the total, and increasing the number of primary physicians in our mix of trainees.

Those primary physicians, if appropriately placed in the community, constitute the major market for our referral services. It is profoundly in society's interest as well as our own to be training fewer people at the higher specialty-end of the spectrum and more at the low subspecialty end.

Third, the growth of physician supply is going to seriously aggravate relationships between physicians and hospitals. But I think it's also going to aggravate the relationship between town and gown in our communities. The balance of economic power is shifting rapidly into the hands of those individuals in the private practicing community. To the extent that we are able, we are going to have to begin to try to heal the breach between the academic physician

and the community physician. We're going to have to make our services accessible to physicians in the community in a way that they really never have been before.

If we can't figure out a way to make it easy for people to get their patients into our institutions, easy for people to understand the range of services that we offer to them, they're going to take their patients elsewhere. At the University of Chicago we're developing what is in effect a catalog of our referral services. We've also developed an office or referral coordinator to provide a one-stop point of entry for referred patients into our system, in effect a VIP admitting track for the referred patient.

We're trying to make it easier to send a referred cardiac patient to the University of Chicago than it is to send this patient to Rush-Presbyterian-St. Luke's.

Fourth, in concern with all of these developments, it's profoundly in our interest to push training and ambulatory services out into the community where the risk and the cost are shared with others. Every hospital is going to have to develop a feeder system of ambulatory services distributed in the community to secure that institution's market position.

The control over the primary care base is going to be the key to controlling the flow of patients into our institutions. What better way to do this than to begin organizing ourselves to place in practice the young physicians graduating from our institutions that do not intend to move on into academic medical careers. If we organize appropriately, we can subsidize their startup; give them technical assistance in negotiating office leases, contracts, privileges and arrangements; and sell them the management services to make them efficient. With these kinds of joint ventures, we can share the risk of generating that ambulatory feeder system without investing millions of dollars of capital in increasingly obsolete organized ambulatory facilities.

Fifth, we're going to have to understand our marketplace. In marketing in particular, knowledge is power, and in our case, knowledge is also humbling. Learning what your organization really looks like to the key constituencies in the community is one of the best antidotes for the kind of flag waving that people engage in when they say we are a national referral center and we don't need to do anything to secure our position in the market.

Every institution ought to have an intimate understanding of the organization of its health care market, the service areas of its competitors, the distribution of physicians in the community, the distribution of freestanding ambulatory services, the attitudes of patients and physicians towards the institution and its competitors. Not to have this information is to be flying blind into an increasingly rocky range of mountains.

Sixth, we're going to have to alter the internal rewards system in our institutions to award those individuals that build their institutions out in the community, incorporating resources of other institutions, and to de-emphasize the kind of empire building that consumes internal hospital resources.

If we begin doing these things, we can take the significant power and quality of the clinical resources that we've inherited and really move in a major way to dominate our markets. There are major external threats to our institutions in the reimbursement system and elsewhere. But it seems to me the most significant threat of all is inside our institutions, in an attitude of entitlement and self-certainty that may no longer be sustainable in an increasingly price competitive market.

The climate in many of our institutions reminds me of the famous Visconti film, "The Garden of the Finzi Contini's", a chronicle of the obliviousness of a wealthy Italian aristocratic family in the first months after Mussolini's takeover in Italy. The intrigues and romances of this privileged family, which owned a third of its community, continued behind the high walls of their estate, while external forces conspired to deprive them of their birthright.

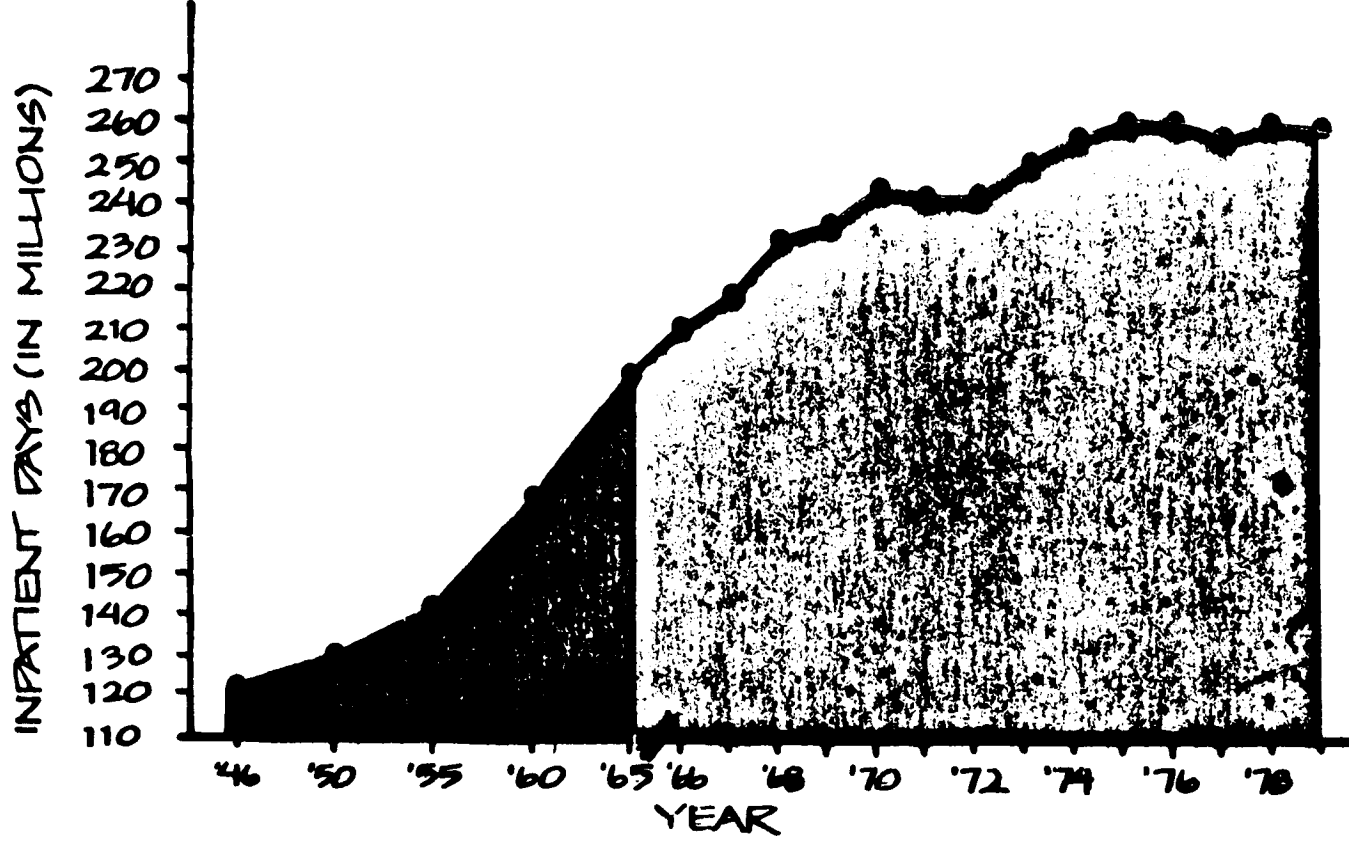
If our institutions treat the position of power and privilege that they have developed in the last 20 years as a birthright, rather than as something they're going to have to fight to keep, ladies and gentlemen, they're going to lose it.

There is a time to contemplate and a time to congratulate oneself, and there's a time to fight. We're going to have to fight to keep the resources that we have. And I believe that if we can mobilize the creativity and the energy of the people in this room to wake up the sleeping giant inside our institutions, many of our own institutions will be stronger, clinically and academically in 1990 than they are today.

Thank you very much.

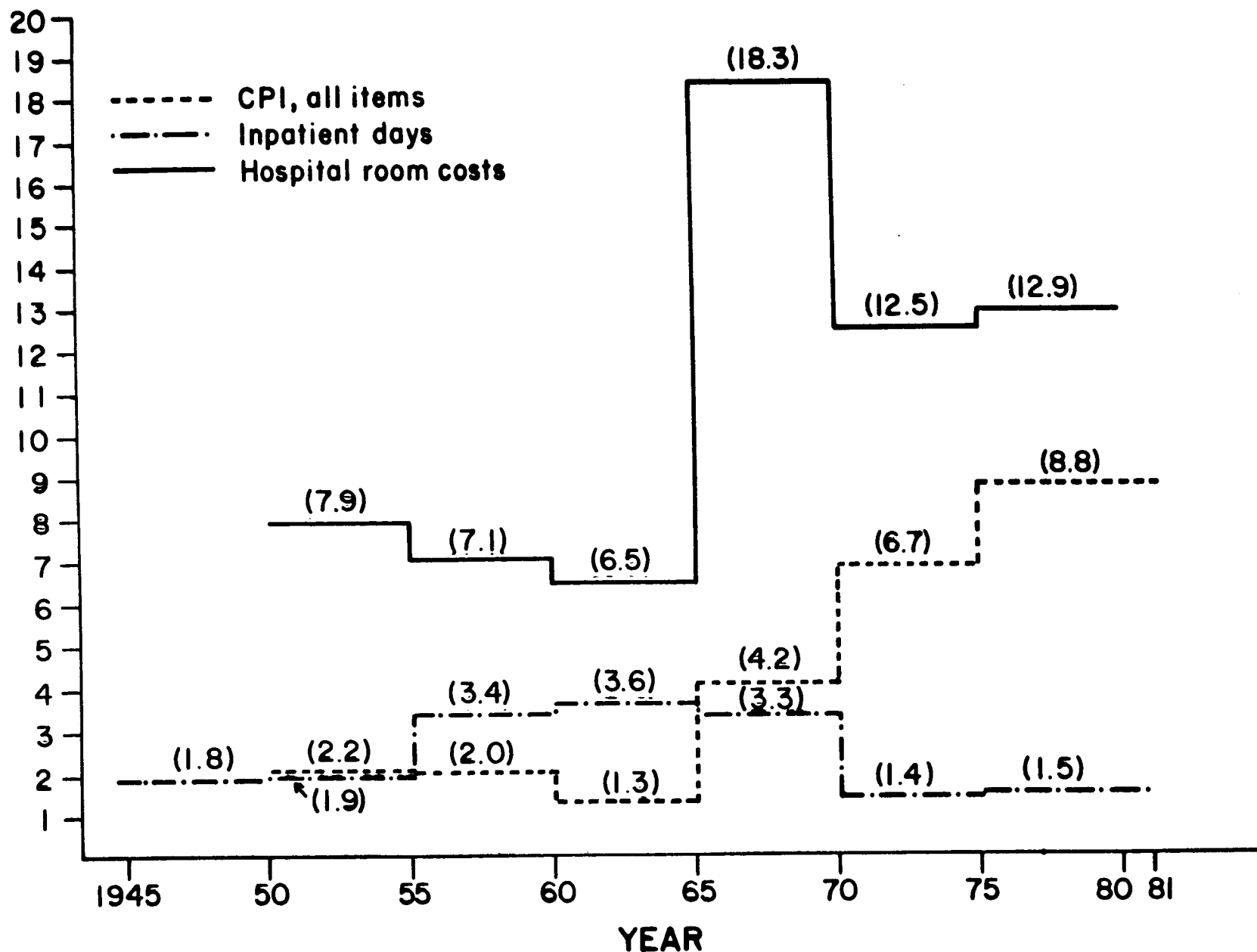


TOTAL INPATIENT DAYS NON FEDERAL SHORT TERM & OTHER SPECIAL HOSPITALS



HOSPITAL INPATIENT DAY AND COST GROWTH

(Average annual percent change)



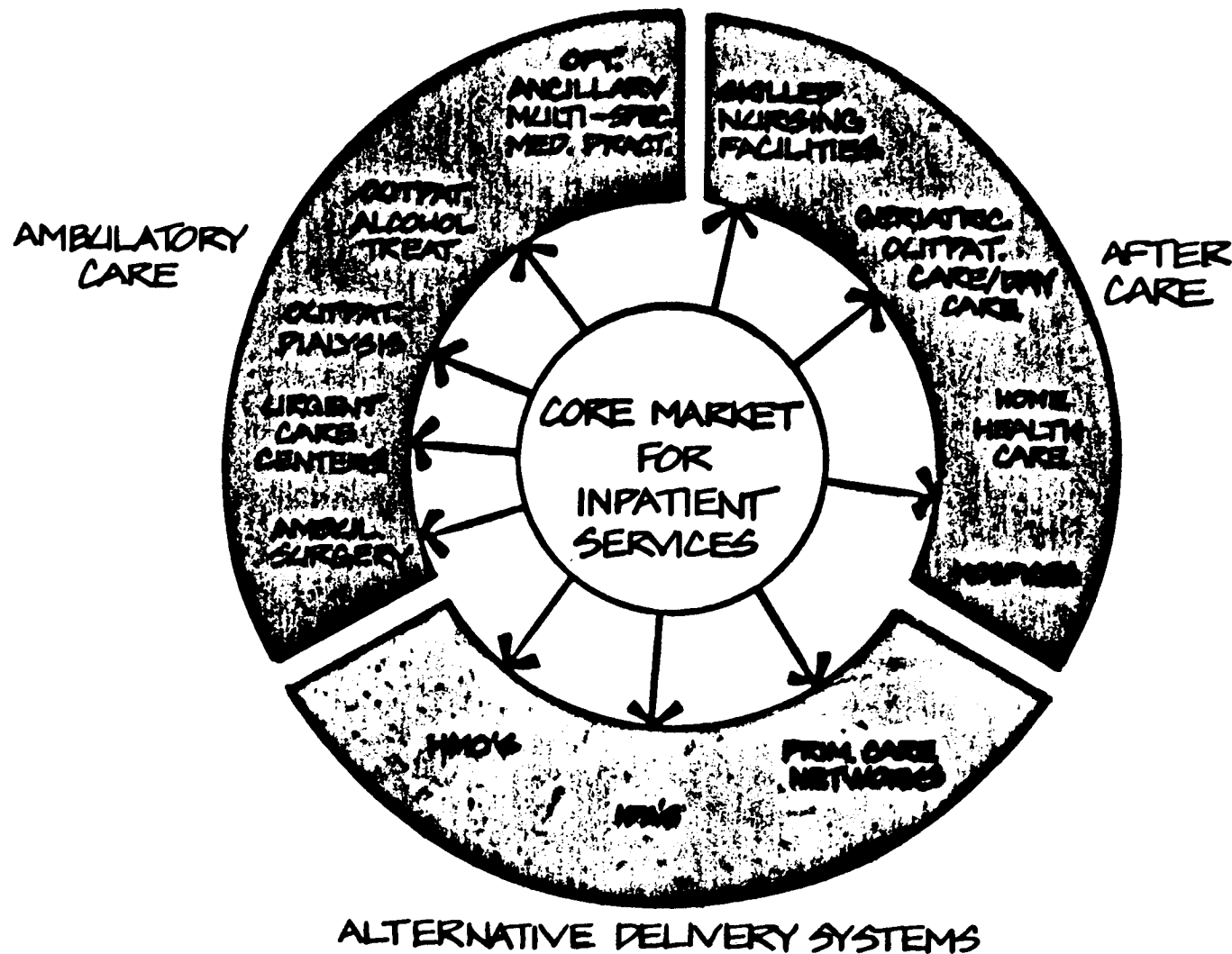
Sources: Bureau of Labor Statistics, U.S. Dept. of Labor : Consumer Price Index
 AHA Hospital Statistics, 1980 Facts on File

**DAYS OF CARE / 1000 POPULATION BY SELECTED
AGE GROUPS (1965 - 1978) SHORT STAY HOSPITALS**

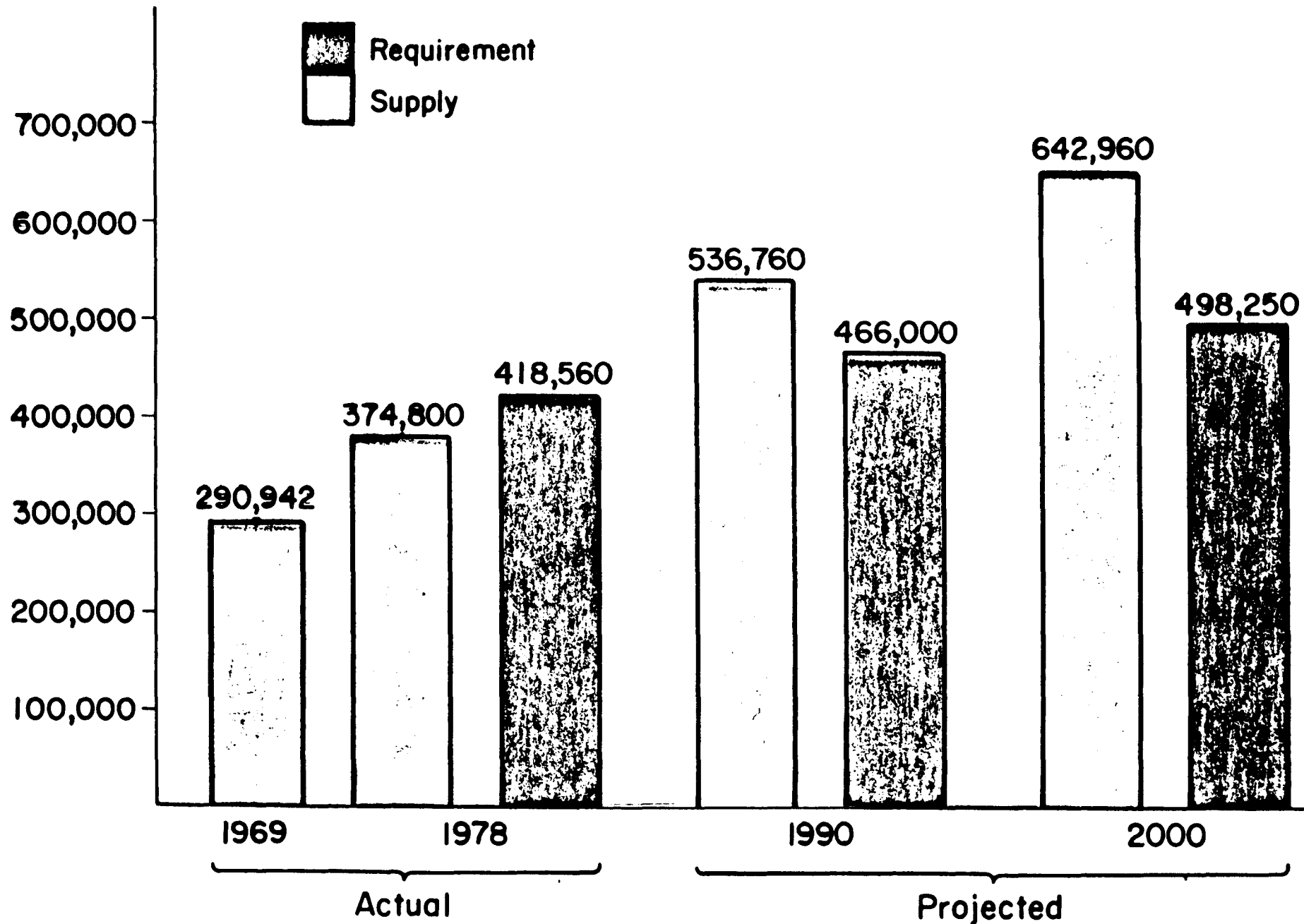
YEAR	ALL AGES	UNDER 15	15 - 44	45 - 64	65 +
1965	1203.4	408.6	1040.2	1710.9	3443.5
1966	1221.4	398.8	1025.3	1718.8	3712.0
1967	1238.9	410.9	1000.1	1634.6	4086.2
1968					
1969					
1970	1172.7	332.9	903.9	1550.0	4015.4
1971	1143.1	327.2	869.2	1535.0	3860.3
1972	1199.9	329.5	886.8	1642.7	4076.8
1973	1211.6	321.9	878.5	1661.0	4136.4
1974	1232.9	328.4	891.6	1701.8	4107.0
1975	1254.9	328.0	885.1	1748.9	4165.9
1976	1236.0	317.2	843.8	1716.8	4163.7
1977	1236.7	308.2	849.2	1688.3	4156.3
1978	1224.9	304.8	824.7	1638.7	4183.8
1979	1223.7	314.7	817.8	1604.3	4182.5
1980	1230.8	316.4	793.1	1607.0	4327.5

**SOURCE: UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND
WELFARE CENTER FOR HEALTH STATISTICS, VITAL AND
HEALTH STATISTIC UTILIZATION OF SHORT STAY HOSPITALS-
UNITED STATES SELECTED YEARS. SERIES 13**

COMPETITIVE ALTERNATIVES TO HOSPITAL CARE



AGGREGATE PHYSICIAN SUPPLY AND REQUIREMENTS 1978 AND ESTIMATES FOR 1990 AND 2000





association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

Presentation by ALLEN M. HICKS

VOLUNTARY HOSPITALS OF AMERICA-A COLLECTIVE APPROACH
(Presentation to Association of American Medical Colleges)
May 1982

I belong to a group of hospital administrators called the Hospital Research and Development Institute (HRDI) which started back in 1972 when 25 of us decided to have a study made to see what common threads we may have. Earl Fredericks was the consultant to that study. The Voluntary Hospitals of America (VHA) movement was an outgrowth of this study.

To put VHA in perspective and indicate where I'm coming from as an individual hospital administrator and hospital operator, I started out as a hospital administrator 27 years ago and I can remember we had the 20-year plan then 15-year plan. When I went to Indiana, I got down to a 5-year plan. In January 1981, I threw out the 5-year plan and decided we didn't have 5-years to make major decisions. We had to get at things if we were going to start solving the problems that I saw on the horizon for the not-for-profit hospitals.

Our institution is 840 beds and our oldest brick is 25 years old. We are really in a good location with everything going for us, but I have watched large institutions around the country over the years get cut off because of population shift or whatever. Today we have the for-profit movement making a strong effort, and I knew we had to move quicker on a five- year plan.

We are now putting the plan back together, but we have done a lot of things in that 12-15 month period, and I know my Board sometimes wonders just what's going on. I remember one Board member not long ago saying, "You know, I missed one meeting...we were talking about 20 acres, and now we own 83."

What happened to make this big shift? You know a lot of those reasons. But in Indiana, we have had a very comfortable system. We have had prospective

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payment for 20 years that has worked well. One thing it has not done is really allowed hospitals to accumulate capital, and if you look at the rural Indiana system of 75 county hospitals, the for-profit system is now targeting Indiana as the state to move into next. They can come in and offer the county Board of supervisors \$2-3 million for their hospital, and then build them a new one on top of that -that's pretty nice for people to at least consider.

So the competitive situation in Indiana, and including Indianapolis, set up a different set of criteria along with all the other pro-competiton movements. It caused me to move quicker and re-accentuate the things that VHA stands for and the things that I think are going to happen.

It's high on my personal list that our hospital remain price sensitive. I think that is going to be the name of the game in the next couple of years.

Customer sensitivity - not just patients, but also relatives are high priority items as we move ahead. There is a need to secure marketshare and not allow your institution to be cut off with free-standing non-hospital facilities.

We had to anchor our marketshare no matter what it took and we had to accomplish it in addition to saving a buck.

It's very difficult to work in a system and work individually as a hospital to save. It's tougher in a system, because if you really start saving a dollar in a system you are stepping on some very important toes, and when you step on the very important toes, all kinds of people start attacking you.

So as I looked at our institution, I felt we had to secure the marketshare. We had to do that immediately. We've picked a target of 4,000 beds for our institution. I'd like to own about 1,200 of those, and the other 2,800 would be in our little system in central Indiana. I see this all happening within the next 3-4 years. Maybe 4,000 is not the right number, but at least it's a reasonable start.

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Secondly, we have to be a part of a national system - and that's VHA (along with a few other national groups we're involved with). And third, we had to get the institution restructured. Restructuring might be somewhat of a fad we're going through and may not really in the end prove to be practical, but I think I would be remiss if I did not have our institution at least posed in the best flexible and potentially competitive mode possible. The restructuring which has now been completed is also a very important part of the VHA movement.

In 1972-73 as they studied the common things that you might do together in a hospital system, malpractice insurance was ranked about 13th as a need. Twelve months later it was ranked number one. Out of that we did start five offshore insurance corporations. We started out with one insurance company that today has about \$85 million in it and ten hospitals that overlap with Voluntary Hospitals of America (VHA). I think that's important because we learned how to work together early in putting the insurance company together.

At the same time we started the insurance company, we started Hospital Shared Services, but could not get the two principals we wanted to run the program. The insurance company escalated and is still going like that. Hospital Shared Services went just the opposite. There's a lot of reasons probably why it happened. First of all, it was a group of friends that started the shared service operation and that's probably bad to begin with, malpractice had a high priority back in 1974 - not shared services, and we just didn't have the commitment or the discipline to make that shared services organization go.

In 1976, Wade Mountz, Stan Nelson, and myself were at a common meeting in Arizona and we got to talking and decided to try and put VHA back together. A few years had gone by and the insurance company had been successful. The three of us knew this would require a tremendous commitment - not just from ourselves, but also from others. We started the planning process in 1976 where about 8 or 9 of us met on a regular basis to see if we could put a national system back into proper perspective.

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We interviewed people that had been successful in various sytem. I might say the farmland co-op in Kansas City today has probably had as much to do with some of the things we're doing as any. That organization does about \$4 billion worth of business a year and it has a lot of the same characteristics that a voluntary not-for-profit hospital has in local autonomy yet tied together in a national-type organization.

After about a year, in October 1977, we incorporated. There were common threads within this group of 30 hospitals and we assumed our growth over the next five years would probably bring those numbers of beds up around the 60,000 mark. But starting out we started with a base, and we do about \$2.5 billion worth of business a year between us. Today, we have about 70,000 employees. So, you see, we really have the firing power. We have the volume if you can just get the commitment and the dedication together. All of us have tremendous potential power within our organizations, and we recognize that being available to us, if we could just get it harnessed and go on down the right direction.

Again, the background in MMI (the insurance company), has helped visualize this by putting it together. The one thing, I am sure, is you have to be patient. We've been at it now four years. We recently acquired the management group from the old Hospital Affiliates Management Corporation. When they merged with HCA, the Hospital Affiliated people came over to VHA and they now run our hospital management office out of Tampa. In their estimation, it took HCA and Hospital Affiliates about 12 years to put that organization together. We have come a long ways in four years, and I hope it's not going to take 12. Personally, my goal would be eight years to see this full system into effect.

I was raised in the not-for-profit system and I believe it is a good system and I see no reason why the system should not survive. The for-profits may have the sparkle and the glory today in many areas, but many of us were part of the Lewin Study, which was a study of the not-for-profit versus the for-profits, and those of you that have looked at that study can see there's definitely a future

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for the not-for-profit system. The 30 hospitals in VHA believe in the not-for-profit system too, and that's a very high commitment.

Going in, the 30 hospitals had rather stable management. I say rather stable, because we all know that that can change overnight in this business, but by and large we did see stability and commonality of our boards and the management of the organizations which we felt was in important in bringing the original group together.

We have all committed to vertical and horizontal growth of our own institutions. As far as our hospital is concerned, it's tied together with a system of 11 small central Indiana hospitals tied back to us as the parent, and everybody in VHA is in that ballgame of both vertical and horizontal growth -and we are committed to that.

The 30 hospitals were large in size. The base hospital averaged around 700 beds. We didn't want to be a buying group. If we were just going to be a buying group we were already in groups that could handle that kind of thing - and we didn't want to be a dominant factor in the organization.

We wanted to create a partnership with whomever we did business (that's becoming a bad word in anti-trust circles, so I'm going to quite using that after today). Our original goal was to be a part of a partnership with the people with whom we did business. We wanted to help other groups get up and get started.

In Indiana, for example, with the 75 county hospitals, the best thing that could happen is that five, six or seven of the large hospitals in the State work with the smaller institutions and protect each other, if nothing else. And if you get the systems up and going, I think you have a great chance to do that.

But we were there to try to help other groups get started. And then last, but not least, was to maintain that competitive edge for the member hospitals. We

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started out with the idea of one hospital in a geographic area, and the idea was to make that hospital have an advantage in the overall competitive marketplace.

So that's how we started out with the idea of coming together and the common threads that we saw in the organization early. I might say that going in we tried to keep our staff small with a central staff operated out of and in conjunction with Henry Ford Hospital in Detroit. We used the lead hospital concept. Our hospital, for example, was the lead hospital in Radiology services and our job was to make sure what we did in radiology happened in the system and we were tied back to a radiology consultant.

We did use the lead hospital concept in about 20 different areas in order to maintain low operating start-up costs. We had a small central staff, and we were heavily involved with consultants. About a year and a half ago, we went through another year of planning which has set VHA's future for the next five years. We have created new headquarters in Dallas and hired Don Arnwine as the new president. Don was the former head of Charleston Medical Center and headed up our planning effort.

We have three regional offices - one in Atlanta, one in San Francisco, and one in Detroit - because of our scattered membership. We do have a growth mode. We're picking up ten hospitals on the West Coast which will be VHA-West, and then on top of that, there's a growth pattern over the next five years that should bring us from today's 40 hospitals to 100.

When you fan that with the small systems that we have operated, it does become a rather good sized system. The members of our management company in Tampa (that's the hospital affiliated group I mentioned earlier) are our fighters - they can lease, purchase or manage a hospital; they can come in and help Community Hospital either fight the for-profit system if they're in the area or compete with them in anyway we feel comfortable; or if I'm after a given hospital in a given area, they would help me bring that about.

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I like the tie with the for-profit management group because it gave my not-for-profit hospital a perspective we haven't had. And quite frankly, I've never operated on that side as a CEO, and I'm happy to have those people available to us as far as taking a look at my own operation in addition to the rest of their management mode.

To join VHA we need a complete CEO commitment, we also have to have the board commitment, and we've spent a lot of time these days on that relationship before the hospital ever becomes a member, because if the CEO leaves, that hospital still is a member. One of the hardest things we have in putting a system together is good communication. I'm at the meetings and I know what's going on, but to communicate that through all the levels of my management back home is very difficult and takes a good deal of time. We're not there yet within the 30 hospitals, but we've gotten better at that, and by the time we reach the eighth year that I'm talking about, I think we will have it throughout.

I have said at every VHA meeting over the last four years, "if you're going to do something in your hospital and if you don't think of the system first and your hospital second, you're not accomplishing the goal for VHA." And all of us sitting here know how hard that is.

Management-wise at Community Hospital today, if we're going to do something I think of VHA first and Community Hospital second...how is it going to fit the system? And until you can get that concept sold throughout the system, you're probably not going to have it running the way you want it to run. It's a very hard commitment.

I want to cover the eight parts of the system the way we see it. These are the eight that we believe in and this is what we're working towards. Number one, if you're going to make a system go you have to have strong corporate institutional management. And that is in place for us now.

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You have to have a productivity and quality control program. You have to have a human resources program - if HCA has done anything right, the number one thing probably has been executive development. If you talk to the young people in that system and look at the way that they advance and get promoted...that's their strength. We feel that that's an important ingredient if you're going to have 30 hospitals tied into a system.

You also have to have a financial system with central reporting. A national purchasing agreement is important. We didn't want that up front, but obviously if you're going to be in a system, you have to have a national purchasing program. You have to have a corporate capital financing plan. I can tell you all about the insurance companies and all the things we're involved in, but if you were to ask me personally why are you in all that, well, I want to save a few dollars up front, and I think we can document a half-million dollars savings a year from VHA preceded by a million dollars the first three years we started the insurance company. That's nice for your board if they can see something in that area.

That's important. You've got to have some up front dollar savings. Capital formation to me is the name of the game in the 80s and 90s. And all my energies have to go towards figuring out a way to keep my hospital technologically strong. Of all these things I've talked about the bottom line is how are we going to get capital. We figure a \$150 billion shortfall in the 80s and if the not-for-profits don't figure out some way to win that capital game, we're going to be in big trouble. So all this other is camouflaged to that one word, **CAPITAL**.

Another part of the system is have our insurance company that we own and control. Community Hospital's 800+ bed budget of \$110 million spends \$11 million a year in insurance in some form -- our retirement program, health insurance, etc. We did get out of Social Security two years ago, and had a trust fund for alternatives established.

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One of our biggest competitors to the non-profit hospital today are insurance companies. INA and Prudential own 25% of HCA. It's been reported they've got all their beds in place, and they will continue to be a tough competitor. If I need capital and I need to recirculate some of that, \$11 million insurance annual expenditure. Some way we've got to turn that around so it's coming to the aid of our institution. So if you're going to have a national system, you have got to have an insurance package in there somewhere.

And the last one is to have some kind of a public perception, a public image building program. All of these eight in our system are either started or in some phase of development. By no means are they mature, but that's what we are working towards.

I can't emphasize enough that if the system's going to be successful it's going to have to work out some way to help with the capital problem. I've always been able to say to our physicians we're going to keep them up to date at least technologically. Over a year ago, I sat on a panel and started thinking about CAT scanning, nuclear medicine, ultrasound and digital x-ray alone, and just what it's going to take in the way of capital to keep our institution current.

I believe in the small system tied back to the big system and I think that you have to try to get your organization in the best position you can. We all work with physicians and for boards and owners and so on, and that isn't always easy.

You're going to have all kinds of potential problems coming down the line, and I guess I want to try to place our institution in the best position I can and do the best I can to maintain those relationships - that's going to be the real test.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"THE WASHINGTON PERSPECTIVE:
POLITICAL AND BUDGETARY
EXPECTATIONS FOR 1983 AND BEYOND"

Presentation by JOHN K. IGLEHART

Thank you, Mitch, for the kind introduction.

At any given time in American society overriding trends plan an influential role in government decision making and in private sector behavior. These trends often dictate directions, generate changes in corporate and individual lifestyles and press every interest to evaluate the status quo.

Clearly the major themes that have dominated society during the whole last five years have reflected a strong antigovernment sentiment, a rekindling of individualism, a back to basics look at competition and free enterprise and a re-examination of the limits of public benevolence.

These trends have been instrumental in not only setting a tone for society but they also have greatly influenced the kind of public leadership that voters have sent to Washington, and for that matter to Madison and Sacramento and Austin and even Boston. In essence these trends have helped bring to power politicians who favor less government, lower taxes and a private sector unburdened by publicly imposed mandates once thought socially useful. The election of Ronald Reagan reflects these trends. One could even say that with his election as President the country caught up with the conservative thinking that he had been articulating for many years.

In any event, I believe it's important to recognize that these trends toward a less costly government were generated from the bottom up rather than from the top down, and while they're most closely identified today with the Republican party, it is by no means an exclusive relationship.

Many of these trends were having a sharp effect in state capitals when Reagan assumed office. For example, Proposition 13 in California, Proposition 2½ here in Massachusetts and New York City's financial peril all signaled a growing public demand for fiscal restraint, a demand that government live within the means of overburdened tax payers.

In short, even before Reagan's call for greatly increased defense

spending and reduced taxes, the growth of domestic programs was coming under sharp scrutiny in Washington and beyond. Reflections included President Carter's hospital cost containment legislation and a warning that he articulated in his last budget about the uncontrollable growth of entitlement programs.

The process of policy making in Washington today is, to say the least, chaotic. But perhaps that's not really too surprising when one takes into account the conflicting forces that make up the process and the painful political agenda with which they must deal. The forces include a conservative Republican administration bent on downsizing government at almost any cost, a Senate controlled by Republicans for the first time in decades, a House of Representatives in which Democrats number a majority but in which the leadership has trouble guaranteeing their allegiance even on key loyalty tests and, in the health sphere, a multitude of private and public interests that have demonstrated a capacity to prosper in good or bad economic times, at least in an aggregate sense.

There are obviously a number of philosophic differences which separate the Carter and Reagan administrations. Specifically, in the health field the philosophic differences seem at once glaring and at the same time quite similar. They need to be sorted out. In the broadest of terms, the Carter administration took as the responsibility of government regulation of the entire health care industry. Thus President Carter's hospital cost legislation sought to control the costs of all payers. The Reagan administration's approach to controlling medical costs is considerably more narrow but tougher and perhaps more socially blind.

The administration's clear emphasis is on Medicare and Medicaid, which together cost the Treasury about \$63 billion in fiscal 1981. At current growth rates spending for these two programs would more than triple by 1990. The administration goes to great lengths not to characterize its assault on the social budget as tougher government regulation. Instead the proposals are described as efforts to make the government a more competitive purchase. In short, the Carter and Reagan administrations share similar economic concerns regarding the uncontrollable spiral of health expenditures, but their rhetoric is quite different, and so is their basic view of the role government should play in American society.

The Reagan administration is aggressively pursuing what the President regards as his electoral mandate, reducing the size of government. The tool for this process is the budget. I do not expect to see any broad health policy proposals advanced that are not done so through a budget context.

In this context federal health programs have really become a pawn in a much larger game, the search for billions to replace the billions lost through Reagan's mass tax reduction. Politics obviously is a very human endeavor, thus what we are seeing being

played out in Washington today is a government that having made substantial social commitments to our most vulnerable citizens, now is unwilling to pony up the money to pay for it.

The process of downsizing is painful, fraught with political sensitivity, and it makes incumbents feel like they are an endangered species. The bounty that America has known for so long has not prepared society or its agent, the government, to deal easily with the competing claims being made on the dwindling pie. The congressional budget process is the only instrument being used to retrench. This process proved in 1980 and again last year that it is capable of reducing budgets, but it does so in ways that do not reflect well on our democracy.

Debate is limited. The process is chaotic, and programs of value to millions of Americans are treated as little more than objects to be traded off. Perhaps the power of private interests in our society has become so strong that government has no choice but to obfuscate its decisions and unveil them in omnibus budget bills only after it's too late to influence their direction.

I believe that policy makers are viewing the provision of health care less as a service today and more as a sphere that is economically out of control. Government is no less frustrated than is the private sector at striving to achieve new balances in a zero sum game.

Of programs one could point to that illustrate the frustration but also point to a willingness to proceed with little debate and even less attention to what the changes will mean in the long run, Medicare provides the most dramatic example for teaching hospitals. From its very beginnings, Medicare has been a reflection of how the private health insurance system operates. Indeed it was based essentially on the way Blue Cross transacts its business.

But Medicare also has reflected another important dimension of society, and that is the willingness of citizens to recognize the elderly among us and provide them with acute health care services at a time when they most need them and can least afford them. Throughout the 1970's Republican and Democratic administrations alike made repeated attempts to cut Medicare in one way or another. These efforts were largely rejected by Congress. As a consequence, Medicare represents 62% of the federal health budget today, and by 1985 the OMB is estimating it will represent 80% of the federal health budget; in other words, four of every \$5.00.

Despite many complaints that one hears about Medicare both from consumers and providers, it serves the elderly well, particularly the very sick. Nine percent of Medicare's eligible population uses 70% of its annual program expenditures. Medicare for the consumer is a real bargain. For example, a man who retired in January 1982 having paid in at the full contribution rate since the program started in 1966, could expect a return of \$7.50 for every dollar contributed, and if that man had a nonworking wife and she too was

eligible for the program, the return would be \$17.00 for every \$1.00 contributed. No wonder the trust fund is endangered.

Medicare over the years has been a very popular program politically, reflecting the power and the appeal of the elderly constituency in the United States. But in the last year important changes have been taking place in congressional attitudes about Medicare. Medicare no longer enjoys the political standing that Social Security cash benefits still enjoy today. Medicare has come under attack in the last year. I would mention four indications to make my point.

The 1981 omnibus budget reconciliation law reduced Medicare expenditures by \$1.2 billion. The bulk of these expenditures derived from increased cost requirements imposed on beneficiaries although there also were some provider cuts. But the important point to recognize is that these cuts were initiated by the Congress, not by the Reagan administration. Of course, once they were offered, the administration readily endorsed them. But at that point, about a year ago, Medicare remained in the President's so-called "safety net".

The second example of Medicare being a program no longer invulnerable was a provision enacted last year that allows social security to borrow between the old age and survivors' fund and the hospital insurance fund. In essence what that means is that the hospital insurance fund, which at this point really is more healthy, will be drawn down through interfund borrowing to shore up the beleaguered OASDI funds.

Medicare's hospital insurance trust fund today faces the prospect of bankruptcy between 1986 and 1990, depending on the assumptions used; it could happen anytime between those years, despite the fact there are two scheduled tax increases between now and 1985.

The third reflection of Medicare under assault is Reagan's 1983 budget, which includes budget reductions of 2.5 billion in regards to Medicare. The latest reflection, and perhaps the most disturbing of all, was the willingness of the Senate Budget Committee, in a plan that it endorsed in the last week, to reduce Medicare expenditures \$5 billion in fiscal 1983, \$8.1 billion in fiscal 1984 and \$10.3 billion in fiscal 1985. The President endorsed this proposal, though Democrats and House Republicans have denounced it.

Well, why are these attitudes changing? Why is Medicare under attack? I think the reasons are multiple, and on most large questions like this they're complicated by a number of factors, but let me just mention several of them. I think the relentless cost increases that have occurred and continue to occur, particularly in the hospital, are one reason for it. Of Medicare expenditures, about 74% are spent in the hospital.

But another trend, I think, which congressmen who spend time thinking about health care, and there are not many of them, worry about is the increasing profiteering that's going on as regards that program. I would mention the views of one figure who is very important to the health field, Senator Dole, whom I really regard at this point as the single most influential legislator on Capitol Hill when it comes to health financing issues.

Senator Dole is very troubled today by the end stage renal disease program and by a number of other programs where federal costs have risen dramatically and where he senses rampant profiteering is going on. Dole is not an individual that one would expect to be an adversary of the health system. He spent three years of his life in a hospital recovering from a war injury, and over the years has really been a staunch advocate of health care, but his attitude is changing. He no longer is so unquestioning. For example, recently he said that the administration's proposed Medicare cuts of \$2.5 billion don't trouble him at all. In fact, he says Congress should be able to make larger cuts, perhaps in other ways but nevertheless reductions of that magnitude don't trouble him.

And another reason generally, I think Medicare is under attack is that health generally as a priority on Capitol Hill has dropped a notch. Retrenchment obviously is no fun either in Washington or out in hospitals or among providers who face a seemingly insatiable demand for service.

I'd like to turn back to the Reagan administration and make a few comments about its stewardship, particularly in the health field. And I suppose you could say that I mention these things because they're troubling to me. The Department of Health and Human Services, a department that represents the poor and the old and the downtrodden in our society has never been less powerful in its relationship with the Office of Management and Budget than it is today. I suppose it's a reflection of the basic beliefs of this administration, but nevertheless, it's not much of an advocate, and it hasn't been from day one, when Secretary Schweiker got together with Dave Stockman in the earliest budget meetings and really was ill-prepared to deal with the kinds of reductions that the OMB was talking about.

But perhaps even more troubling than that to me is this administration's stewardship of the Health Care Financing Administration. Indeed though it has gotten far less publicity than the kind of activities that have been going on at the Environmental Protection Agency, the sort of massive attack on that agency and its mandate, I think similar things are going on at the Health Care Financing Administration, and I would just cite one.

When Carolyn Davis became administrator of HCFA, she came to the job with no management experience and with little knowledge of Medicare and Medicaid, and I suppose believing the campaign rhetoric of the administration and of the victorious president

she decided that HCFA could operate with far fewer employees than it had. Indeed it had at that time about 5,000 employees, and she suggested that HCFA could operate with 4,000.

Well, OMB liked that idea, as you might imagine. And they said, well, we'll accept that, and we'll raise you, and they dropped it. Now the fiscal 1983 budget includes an employment level of about 3,800, which is just not enough people to run an agency that spends about \$50 billion a year. I would maintain that lean government cannot afford to be incompetent government.

Another troubling dimension, I suppose, for me of the current environment in Washington is that there is so little debate going on of the really basic and major issues, questions and policies that are being decided really through the budget process. The debate on regulation versus competition has never really been joined. Such a debate really takes presidential leadership, and certainly the President has demonstrated that leadership in other areas, particularly in the economy, but there has been little attention paid to health care despite its massive size.

You might even maintain that the administration has stifled debate on some issues through the President's resistance to consider not only reductions in government support for the poor and the elderly, but also subsidies for the middle class. I would just cite one. The \$24 billion tax expenditure which we spend annually as a consequence of making deductible employer contributions for employee health insurance premiums, when that was taken to the President and recommended to him really by the Department of Health and Human Services, he rejected it and said, no, you can't do that because that amounts to a tax increase. Now the administration has reversed its position in the latest Senate Budget Committee budget compromise and said, yes, we will endorse that not for health reasons but because we need the revenue.

I haven't spent a lot of time talking about teaching hospitals because I figured that you knew that world better than I did, but I would like to mention just several things which I hear about teaching hospitals from people that I talk to in Washington as I'm making my reporting rounds.

I think, generally speaking, Washington perceives that many teaching hospitals suffer from weak managements, particularly public hospitals, also managements with less control than is needed to run institutions of that dimension. I think there is a feeling among staff in Washington if not among the elected leaders that some of the large teaching hospitals are still living in yesterday's resource rich world, that they haven't begun the process of downsizing. I hear a lot of comments about the departmental organization of teaching hospitals and the concern expressed by some that every physician is an entrepreneur.

I also have the sense that there is increasing pressure to more clearly identify components of the cost of a teaching hospital.

That seems to be going on in a variety of different ways both in the government and within your own association.

There clearly are not any easy answers today about Washington, how it operates, where it's headed, but I suppose mostly I am an optimist, and I feel while this process is going on, while it's chaotic, while it's difficult to penetrate and influence, I think it will pass. But I think the thing to remember is that this is not a Republican phenomenon, but I think it's a society-wide phenomenon. Something happened in the 1970's. There have been really massive shifts in public opinion about the level of government expenditures, and it was the blue collar worker as well as the country club set that elected Ronald Reagan President, and I don't think their attitudes really have changed much, although they might be somewhat disenchanted with the President at this point.

But I think the process, as I say, of downsizing will go forth whether the President is Republican or Democrat. And I suppose if there's one thing to hold on to, health care remains society's most highly valued service, regardless of what's happening today in Washington. And while this downsizing will occur, I think health care institutions and the individuals who operate them must bear that in mind as they go through this painful process.

Thank you.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"COMPETITION CONFRONTING UNIVERSITY HOSPITALS: ITS IMPACT ON PATTERNS OF GOVERNANCE"

Presentation by MYLES P. LASH

Dick Knapp asked me several months ago to speak on the subject of competition from the perspective of the director of a large university owned teaching hospital located in one of the most competitive communities in the United States. Additionally, he asked me to introduce the study on governance which is being sponsored by a consortium of teaching hospitals, a group whose genesis is familiar to many of you. The issues of governance are obviously inextricably linked to our future institutional competitiveness. I will attempt to outline the particular environment in which I am working as well as present some of the issues relating to competition which clearly must be addressed by teaching hospitals. I will move through this information rather formally and unfortunately rather hastily, since I was allotted only a few minutes on today's agenda. There is no pretention that my observations are anything more than a personal appraisal of our increasingly competitive operating environment. In speaking on a somewhat similar topic earlier this year, Bob Baker from the University of Nebraska summarized my remarks by saying, "Don't worry about competition coming, it's already here!"

I must begin my presentation with the observation that it is somewhat amusing to see individuals reacting to "competition" as if it was a new issue for academic health centers. You do not need to be too experienced to recognize that competition has been a very real issue for teaching hospitals for quite some time. We compete for patients requiring tertiary services, we compete for patients with third party insurance, we compete for physicians, and we compete for franchises which designate us as referral centers; i.e., trauma and perinatal centers, etc. What is new for us is that the competition rhetoric in the political arena is not only growing louder, but it also is far more articulate.

Last year the legislative articulation of the concept of competition shifted to one particular aspect of that model and that was "consumer choice". The economic philosophy which dominated Washington reflected a renewed interest in encouraging the health care industry to adopt the competitive attributes of the private sector. The popular interpretation of that economic philosophy was that inter-institutional price competition for specific services would ensue. I predicted in a speech earlier this year to the Council of Academic Societies that the possibilities of "gas-war" style price competition was a bit overstated, but acknowledged that changes in the current payment system were inevitable.

A careful look at the issue of "competition" today is revealing and reflects an enhanced degree of maturity on the part of the various constituencies' interests in fostering cost constraining behavior. Without question the legislative proposals that were offered during the past 18 months recognized the main issue clearly. Hospital costs continued to escalate at an unacceptable rate and the existing reimbursement system lacked the appropriate incentives to be a constraining factor. The proposals were theoretically simplistic, but they would have been bureaucratically difficult to manage. Additionally, during the past 12 months the status of our economy continued to erode and the requirement of the federal government to generate more revenue became an overridingly important issue.

This is reflected in proposals which would cap the health insurance premium exclusion from income tax. This approach fosters competition in a unique way, but more importantly, holds significant potential to generate federal revenue. Other legislation has encouraged the use of tax credits for purchasing health benefit packages and the use of a voluntary voucher system for Medicare. These "competition" proposals focus more on the "demand" side of the equation. Incidentally the "executive" branch has still not submitted its health competition bill which most of us were expecting earlier this spring.

I would give all of these proposals a low probability of having a significant impact on the health delivery system in the short term. However, I must admit the idea of using a volunteer system of Medicare vouchers appears to be gaining significant support.

One other area of activity which warrants careful attention is the initiatives of the major insurers like Blue Cross. Contrasted against the hoopla created by last year's legislative initiatives, the relatively quiet approach used by the "Blues" and others to introduce demand forces into our health economy are of major significance. The basic Blue Cross contract has been modified and introduces more cost sharing items, like deductibles and co-payment provisions. As an employee, next year the Blue Cross deductibles in my contract go up by over 100% -- How many of you face similar situations? Additionally, the use of more "co-payments" on previously fully funded "state" indigent patients is being encouraged by many state officials and has already been recommended in Virginia. This approach would theoretically be used as a mechanism to offset growing Medicaid deficits. Unfortunately, the problems it could foster have obviously not been fully appreciated.

Regardless of whether the form is the enactment of a major bill, the initiation of a tax law modification or the implementation of more cost sharing insurance proposals, the outcomes will encourage price oriented competition. All of these initiatives foster an increased degree of consumer involvement in identifying directly with the issues involving the cost of health services and hospital based care. Therefore, they are responsive to the positive attributes of the pro "consumer choice" health delivery schemes.

Incidentally, the competition alternative to modifying the current reimbursement program may not be as onerous as a continuation of the regulation-based cost containment strategy, such as the continued expansion of the Section 223 Medicare payment limits on ancillary services. HCFA is very active in developing methodologies to implement federal cost reduction strategies.

Let us now turn our attention to the introduction of competition per se and frankly admit that it will have a significant impact on the current equilibrium and could possibly devastate the larger teaching institutions which operate with the most complex academic and service agenda.

All of the "competition" models being actively debated on the hill and being implemented by private insurers have been advised to hold down the escalating cost of the government's and the employer's bill for medical services. If the trend toward competition continues, our milieu within the academic medical center will undergo drastic changes. I concur with a comment in the AAMC 1981 position paper which implies that the question of whether the trend toward competition will continue is really moot and states that, "...for teaching hospitals, medical schools, and medical faculty the question may be how to influence, anticipate, and organize for the possible change."

Academic health centers brought pressure to bear on the legislative debate by identifying that our case mix differentials are unique which leads to substantially higher teaching hospital costs. The formulators of the competition legislation are not naive to this point and their leading spokesman, Alain Enthoven of Stanford University "...favors identifying the costs of teaching and research activities and defending each on its merits." This has led Congressman Gephardt to suggest to the AAMC a possible pooling of funds to partially subsidize the teaching costs within our institutions. This approach causes apprehension because it leaves the most costly medical centers deeply reliant on a subsidy from what will predictably be an underfunded resource reserve. Dr. Robert Heyssel, at the last AAMC Annual Meeting, noted his concern with this approach as it related to the impact on training programs. He also reminded us of the unappealing fact, "that funding would become a political negotiation on an annual basis concerning the size and location of the student body."

Debate will continue on these competition bills. Additionally, many of you and the institutions you represent will face an increasingly competitive environment within your local communities irrespective of whether major legislation encouraging competition is passed.

This situation will raise serious questions such as;

- Can university hospitals continue to subsidize
 - the academic mission?
 - delivery of indigent care?
 - advancing medical technology?

What will be the impact on your institution on

- medical education?
- charity care?
- research technology and tertiary care?
- quality of care?

It is important that competitive pressure is growing in this country which does not only relate to the legislative interest in competition. The increasing supply of physicians is an important variable to be considered. Since 1975 the general population in the Richmond metropolitan area has increased by approximately 14% while the physician population has increased by 25%. Additionally, independent providers of medical care will dramatically move into some of our more profitable areas of ambulatory care services. While powerful new hospital chains, both for-profit and not-for-profit, will offer competition to our tertiary care services, heretofore reserved to only the larger institutions which could acquire the the costly resources needed to supply these services. Additionally, the competition which some of our teaching hospitals confront from certain HMO groups is extremely significant. The issues which HMO's force teaching hospitals to address are most notably:

1. Admitting privileges for HMO physician;
2. Availability of clinic and office space;
3. Competitive price structure within university hospitals.

It seems that "the only franchise that we will not have to compete for is in the provision of medical care to the indigents!"

It is important to note that one of the main reasons why the chains will continue to expand and improve their competitive position is their ability to attract capital. In an era where capital markets are becoming rapidly inaccessible, this situation warrants consideration by academic institutions which have a tremendous need for capital during the next decade.

I will now focus my attention on my community of Richmond, Virginia which has approximately 630,000 people in its metropolitan area. The capital of the South is located just 100 miles from Washington, DC. Although it is a rather pleasant place to visit, for the practicing academic physician and certainly for the administrator of their teaching hospital, some of the zing has gone out of our mint juleps due to the increasing pressure of a highly competitive medical market place. Of the 13 non-federal acute care hospitals in Richmond, 46% of the beds are controlled by proprietary chains, the largest of which is the Hospital Corporation of America which now controls 1,317 beds in six hospitals. This has created a highly competitive and not particularly friendly environment in which to maintain our teaching and service programs. I should add that with this type of market configuration, I don't have any confidence that "anti-trust" actions will deter the growth of hospital chains. If the Justice Department did not try to stop the acquisition of Hospital Affiliates

by HCA after specifically looking at the situation in Richmond, then it is rather apparent that it will not be a major force in impeding the growth and development of large hospital systems. This is due mainly to the body of anti-trust law which is concerned with activities that negatively impact competition per se and not how an action will impact a specific competitor, even if it is a socially relevant institution like a teaching hospital.

We have also seen in Richmond the development of a number of independent providers of care, such as surgery centers as well as a recently opened freestanding emergency care center. Another interesting aspect of our situation is the dramatic increase in advertising of hospital services.

The most recent competitive activity which has taken place in my community is the announcement by the Prudential Life Insurance Company that they plan to expend between \$12-20 million on developing an HMO. The program, called PruCare, will have a number of satellite sites. This major decision was made with very modest input from the local hospital and physician community. This form of price sensitive competition obviously causes us concern.

I think this new competitive environment is going to force all of us within academic medical centers to step away from our routine operational problems and develop comprehensive strategic plans to cope with this situation. Inevitably, it will force the academic health centers and their parent universities to review the effectiveness of their decision-making processes as well as the issue of governance for the university-based teaching hospital.

Although these observations may be somewhat premature, I would suggest that some of the effects of competition on medical education would be:

1. Viability of the teaching hospital threatened;
2. Reduction in hospitals' financial support for teaching and research;
3. Increased reliance on private practice income;
4. Increased strain on hospital/university relations;
5. Altered academic relationships with affiliated institutions;
6. Size and type of case mix in university hospitals altered;
7. Participation in new modes of health delivery;
8. Continued cost pressure impacting practice patterns;
9. Governance structures reorganized;
10. Selected institutional failures.

Donald MacNaughton of HCA summarized our dilemmas quite accurately when he noted, "that academic health centers are keenly affected by the national economy, the changing demographics, and perhaps more directly, the widespread questioning of government's role in financing research, education and social services. The financial dilemmas posed by the elimination of capitation payments, the leveling off in federal financing of biomedical research, the fiscal shortfalls faced by many state Medicaid programs and the possible intensifying of hospital price competition - all pose a threat to the future of medical education and research." It's always nice to hear

what your competition thinks of your survivability!!

Surviving was exactly the issue when a group of teaching hospitals met together over two years ago. We met as a consortium to study issues unique to university-owned institutions. There was complete unanimity that our first study topic should be a review of the question of governance. More specifically, we felt enthused about the possibility of independent and well credentialed researchers analyzing the different patterns of governance found within our various institutional settings. We felt strongly that this analysis could help us to understand whether any significant correlations exist between these patterns and the operational viability of our individual hospitals. The researchers personally surveyed a number of academic health centers with differing forms of governance such as Minnesota, North Carolina and the University of Florida.

Admittedly, many of my colleagues, including myself, feel that certain attributes of the governance structure of university-owned facilities have constrained and will continue to inhibit our ability to effectively compete in an increasingly complex health care marketplace. However, I must note that the researchers had complete independence from their sponsors. In fact, I don't know exactly what Fred is going to say today, but he did ask for a short introduction that would outline the context of his research team's efforts. Additionally, he told me not to raise too many expectations with respect to the study's tentative findings. Fred, I have tried, but I admit that I had trouble constraining my hopes that your study of governance will help provide some truly productive insights that will enable us in the university setting to improve our competitive position.

I am pleased to introduce Dr. Fred Munson to discuss the consortium's governance study.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"NONHOSPITAL-BASED COMPETITION: AN ENTREPRENEURIAL VIEW"

Presentation by KARL G. MANGOLD, MD

"Nonhospital-Based Competition: An Entrepreneurial View"...
Approximately 12 years ago, people began to call me an entrepreneur. I always felt silently complimented, although it was usually stated in some kind of derogatory context such as "medical entrepreneur." I am not really sure what a medical entrepreneur is. However, I didn't want to disappoint you so I hope you all picked up the glossy promotional material of the Fischer-Mangold Group as you came into the room today. The Fischer-Mangold Group is a group of 220 physicians and 40 lay employees including a management team. The nature of our business is specialization in emergency medicine, freestanding ambulatory care facilities, occupational medicine and geriatric ambulatory care. I guess you and I represent the most successful benefactors of a very bloated industry. Think about it! The United States, the most productive country in the world, increased its health care consumption from five to 10% of the Gross National Product in the last 15 years. The United States of America, the most successful country in the world, has given the health care industry a blank check. Many of you have come into the health care system simply because there is money here. People always go where the money is. However, increasingly it is recognized that we have been in an era of survival of the fittest. We have clearly entered the nadir for health care institutions being guaranteed their existence simply by participation.

Many of you should get your resumes up to date because you simply are not needed in this industry. I and people of like mind are going to help you apply for jobs in other industries. I am going to be generous and even show you why and how I intend to participate in eliminating many of your current jobs. I am sure that this sounds very confronting. On the other hand I see little to be gained by beating around the bush. After all, we all have the same philosophical goal. Most of you represent the hospital industry and are aware that there is an increasing scramble for the health care dollar. Well, I think many of you are providing hospital services that I can provide in a nonhospital-based environment at half the cost, in half the time, by courteous people. Think about it... a nonhospital-based service delivered in half the time, at half the cost, with a smile!

I don't understand some of the concepts discussed by previous speakers, such as "high penetration of organizational-structural inter-relationships." I don't presume to understand the patterns of governance of university hospitals. However, I certainly understand

patient satisfaction and quality care in emergency medicine. These are the parameters that I use as a reference point.

My introduction to medicine on my first day at medical school was a very positive one. Some of the brightest people I knew in high school and college went to Cornell University Medical College. I almost didn't apply because I really didn't think I would get in. However, I was accepted. The first day, Victor Marshall, MD, Chairman of the Department of Urology got up and said, "Folks, we've chosen 88 of you out of 1,273 applicants. You're all going to be doctors, if you want to be. You all have the capabilities to become physicians. If you have a problem, come to us. We on the Selection Committee know what we're doing and how to choose people. We aim to support you if you have any difficulties on your trip through Cornell Medical College." I found it liberating. Such an enlightened, nurturing, supportive approach. I thought, "Wow, this is going to be pretty cool!" And that's exactly the way it was from 1960 to 1964; very supportive and nurturing. I felt like the king of the hill as a medical student at Cornell. It was an extremely positive four years. I and the people around me had the same goal...to make me the best possible physician I was capable of being. I want to re-emphasize the words supportive, nurturing, and liberating.

The first night I worked as an emergency room physician in 1965, I was a moonlighting military doctor. This was before Medicaid and Medicare. Those of us who practiced medicine before 1966, or were in the hospital or health care industry before Medicare and Medicaid, have some vision of the future because we have lived in the past. The future will be an amalgamation of the best of health care delivery before and after 1966.

It may seem a digression, but let me tell you what happened to me that first night in the emergency room. I worked as a hospital employee, earning \$2.08/hour and \$5.00/patient. I attended two patients in 12 hours and earned \$35.00. One of the patients was a heroin addict who came in spiking a fever and was hypotensive. I called an internist on the staff...there was no oncall list...and I described the patient. The internist's response was, "Certainly, put him in the hospital and I'll be right there to attend him."

Well, then Medicare-Medicaid came along, and by 1968 my call sounded something like this: "Hey, Harry, this is Karl. I have a 54-year old female with Blue Shield insurance who has acute pancreatitis, is hypotensive and must be admitted to the Intensive Care Unit. When do you think you can get there?" And the answer was, "Oh, I'll be there as soon as I can. Hey, Karl, do me a favor. Write the orders, OK? And, do you really think I have to come in tonight? Couldn't she wait until morning to be seen?"

The professional and peer relationships that I had with the other members of the medical staff had substantially changed. I was accepted as a colleague and prior to conversation with other medical staff about my patient, I first ascertained the positivity or negativity of the patient's wallet biopsy. It saved me from answering the inevitable

question, "Does the patient have insurance?"

Medical care is first and foremost a human contact. That's where the rubber meets the road. That's where humanity and science and business merge. I haven't heard anything at this conference about the context, the milieu, the ambience, the quality, the caring, the nurturing, the competency, the timeliness and the courteousness of the doctor-nurse-patient relationship. I have heard that medicine is an art, a science and a business, all of which must be kept in balance and harmony. Without that harmony, all of these other lectures are nonsense. The ambience of that patient contact must be kind, courteous and competent, no matter how difficult.

I have spent 17 years developing an emergency medicine system because I felt that one day with my type-A personality I'm going to have an acute myocardial infarction and I want to be given an opportunity to survive!!! And that's what the hell it's all about. Unless you and I develop a system that puts the patient first and money, power, politics, turf and status second, we are not deserving of participating in this industry. I know it sounds hokey, but it's what the public expects and pays us for. That is our responsibility to them.

So, for me the key is patient satisfaction. If medical care feels lousy, it is lousy! I believe it was Ted Cooper who said, and I'm paraphrasing, "Never have we been able to provide so much and never has it felt so poorly." If that's true, and I believe it is at least to some degree, it is an insult to all of us because medicine is an art, a science and a business which must remain societally responsible.

Earlier I heard a wonderful word in the keynote address, "downsizing". I love it! If you want to downsize your institutions, you had better put them on clear liquid diets because that is what it is going to take. You hospital CEO's kept your jobs in the 70's by finding out how to get the most from the National Treasury. That was your mandate -- maximize reimbursement. You had a direct pipeline via the Medicare cost report. The politicians gave it to you and you outfoxed the bureaucrats again. Those of you who kept your jobs did so by finding very competent comptrollers and chief financial officers. You learned to maximize the gimmick of running a financially successful hospital. Your hospital boards understood the game of financial-government cost reporting and played it to the tune of \$100 billion a year. I think you can stand to lose a lot of weight and can wind up in much better shape.

Those of you who plan on keeping your jobs in the 80's and 90's will hire, or already have on board, top notch competent marketers advertisers and public relations people to neutralize your flagrant business-like approach. Many of you losers will close your doors and society will benefit from that. I think a number of you will be found among the hospital body count. And others like me are going to try and help you get there because no one has the right to exist simply by participation rather than through results and meaningful contribution. The winners in the 80's are going to be those who employ

strategic planners and hospital marketers. Those of you who do not attract and retain top-notch health care marketers to the same degree that you attracted top-notch chief financial officers will lose your jobs. And, remember you here today are the most successful big spenders of a big spender industry! You're not the average hospital administrator or chief executive officer. You represent the cream of the crop, the big hitters.

I want to give you a little example of marketing.

RECORDED PRESENTATION #1: "Now there's a new concept in urgent medical care. It's the Shields Avenue Medical Group, a walk-in medical facility open 9:00am-9:00pm, 365 days a year, with no appointment necessary and a minimum of waiting. Shields Avenue Medical Group offers the professional care of an onstaff physician when the specialized services of a hospital emergency room are not needed or your personal doctor is not available.

We also provide nonemergency medical procedures such as physical exams, blood tests, pap smears, and preschool physicals. And in most cases the cost will be lower than emergency room fees. Next time you need swift reliable attention, remember Shields Avenue Medical Group, open 9:00am-9:00pm, seven days a week at 199 West Shields between Fulton and Paw. Shields Avenue Medical Group, fast, efficient medical care when you need it."

One of you in the audience should recognize these.

RECORDED PRESENTATION #2: "What would you do if someone you knew suddenly had a heart attack, if every second counted and your reactions could mean the difference between life and death? Chances are if you had classes in CPR you would know. Cardiopulmonary resuscitation, it's been responsible for the saving of countless hundreds of victims of electrocution, severe injury or attack that has caused the heart or lungs to stop functioning. Now Shields Avenue Medical Group in conjunction with the American Red Cross is offering classes in CPR every Tuesday and Thursday from 6:00-9:00pm. For a slight registration fee and only six hours of your time you can learn these special lifesaving techniques. For more information, please call the Shields Avenue Medical Group at 225-4706. That's 225-4706, because you never know when a heart attack may strike someone you know."

Now here is the last paid commercial announcement.

RECORDED PRESENTATION #3: "Now there is a new concept in urgent medical care. It's the Shields Avenue Medical Group, a walk-in medical facility open 9:00am-9:00pm, 365 days a year, with no appointment necessary and a minimum of waiting. Shields Avenue Medical Group offers the professional care of an onstaff physician when the specialized services of a hospital emergency room are not needed or when your personal doctor is not available. And in most cases, the cost will be lower than emergency room fees. Next time you need swift, reliable medical attention, remember, Shields Avenue Medical Group, 199 West Shields between Fulton and Paw. And now Shields Avenue Medical Group

in conjunction with the American Red Cross is offering classes in CPR, cardiopulmonary resuscitation. For a slight registration fee and only six hours of your time you can learn these special lifesaving techniques. For more information please call Shields Avenue Medical Group at 225-4076, that's 225-4076."

This available immediate care center is in Fresno, California. Our collection rate is \$.97 on the dollar at the time of service. I have spent 17 years in emergency medicine attending any patient who presents himself at any time, 24 hours a day, seven days a week. To me our collection rate in this nonacute ambulatory health care facility is astounding. However, it is very close to your hospitals and most doctor offices' collection rates. These freestanding facilities skim just like you do. In the freestanding facilities we require a positive wallet biopsy before service is rendered; just like you in the hospital. Now I know there are exceptions to this generality, but many hospitals clearly are not. We all know that in 1982 there is practically no bad debt in most hospitals with reimbursement from the government and insurance carriers. We also know that the costs are in some cases outrageous!

So now we have a freestanding facility and we're acting like almost every other office-based doctor in this society. I think we have an enormous future. In fact, we have formed a separate division in our Fischer-Mangold Group to meet the needs in unscheduled primary care. We feel that we have a formula for success. We have job descriptions on paper, we have the physicians, we have three facilities in operation. We have done ten consultations for either hospitals or individual groups of physicians. Many of you speak frequently about hospital organizational structures. But I haven't seen many of you put incentive-based physicians into the formula. Most of you feel that the majority of physicians will work on a salary. However, you should be careful. Physicians are waking up. They now can rapidly organize into health care delivery teams and can dramatically reduce the number of patients in the hospital because of their convenience. Physicians have decided to be creative and can do it outside the hospital. However, physicians also are interested in unbundling hospital services and returning the hospital industry to caring for only really sick patients. We recognize the need for top-notch management people. So if you think I was confronting by asking you to polish up your resumes, I may also be offering you jobs. In fact I would be privileged to hire the best and the brightest among you.

In my experience, two kinds of people go into hospital administration ...wimps and samurai. The wimps have traditionally worked with physicians because they've got the MD degrees and the wimps don't. The samurai usually go into the hospital field and wind up fighting with doctors. Top management people usually go into industries where there is a close correlation between their rewards and their results and responsibilities. However, while you're fighting with your medical staff, I'm going to try and steal your patients!

Physician groups are going to be nibbling away like termites at your foundation. And, if you think I'm Che Guevara, you had better realize that there are a lot crazier guys than me out there. Take a look at this industry; fancy hospitals, megacapital expenditures, high technology buildings full of highly specialized physicians who are best paid when they do something. Thus a direct extension of this high technology industry has been doctors and hospitals that underestimate the importance of the art of medicine and assume that an increasing percentage of the nation's gross national product will continue to be spent on health care. Do many procedures and get paid a lot. That's health care reimbursement.

Most physicians are located close to hospitals. Why? Because the doctor doesn't want to lose all that money and travel time. Because many of you built doctors' office buildings to keep doctors close to your hospital. Not a bad strategy since there are only two things that you can really manage: 1/ control and 2/ money. We in the newly evolving freestanding nonhospital-based competition, after doing our demographic research, plan to put our facilities where they aren't present. Society is changing rapidly. When one reads Third Wave and Future Shock, one has to conclude that the electronic cottage industry is coming. So while all of you are commuting to those big fancy buildings, I am going to be building freestanding facilities not only where people are living but also where they are working. And I am only going to treat the paying ones because the freestander is convenience medicine, not essential medicine.

The hospital industry has increased costs at twice the rate of inflation since 1967, double digit deficit spending. In 1983, the government budget will bring Americans triple digit deficit spending. If you are a farmer in Iowa who's just lost your farm or your crops are selling at prices so low that you cannot make ends meet and you are going increasingly into debt, you have to be kind of angry. If you are a factory worker in Decatur, Illinois and you've lost your job and your union benefits have run out and the factory is closed, you must be kind of angry. This recession has even hit California, where General Motors recently closed an auto assembly plant in Fremont. I think you ought to take real notice because the fall of the auto industry in America is due to the failure of management and unions to work together and meet changing realities.

Well, now's the time for tough management decisions in the health care industry. Now is not the time for do-gooders or bureaucratic, self-contained, cost-reimbursed administrators. Many of you have been successful managers in the past under cost reimbursement. I am not so sure you are going to make it in the future under prospective rate reimbursement and flat out competition. Anyone can manage your hospital when revenue is expanding by \$5 to 10 million a year. However, that's not management. That's just being lucky, being in the right place at the right time when people are throwing money at you. In the next decade we're going to see who can manage the health care industry. In the next ten years the real managers are going to survive and the less competent ones are going to have their resumes ready. Those people in Iowa could give a damn about your Medicare cost report. They'd like to

see some chief executive officers unemployed. They'd like to see some unemployed doctors. In this society when one receives an MD, one has instant status and instant income for life. The best move I ever made was going to medical school. There is no question about it. Now is the time for physicians to "give back" and once again become active in their communities. They should go back to making money the old fashion way, by recognizing a need and filling it.

My career in emergency medicine has been very interesting in many ways. I learned early that many hospitals are financial institutions which happen to be in health care. I am very suspect of much that I hear from some hospital administrators because early in my career I naively believed that an emergency department admitting 10% of 23,000 patients a year loses money for the hospital. I like a dummy believed an administrator who told me this. What can I tell you? However, I began to calculate and found that the emergency department admitted 25% of the inpatients, accounted for 30% of the inpatient days and 35% of the inpatient revenue. The administrator told me that I just didn't understand hospital departmental cost accounting. And I said if a department is hurting so bad, amputate it. Close it. I also took courses in hospital economics.

The other event that resulted in the jig being up for hospitals was not Reagan's arriving Washington, it was the Freedom of Information Act. I obtained some of the hospital's cost reports and took them to Arthur Andersen. Those costs reports were interpreted for me and I found out all the nonsense that was allocated to my emergency department. Comparing this to what was being told to me by the administrator I wound up being a real skeptic! I became really cautious and began not to believe very much. I also learned how to read the numbers.

The best marketing endeavor that our Fischer-Mangold physician group ever did was to obtain 50 hospital cost reports from Medicare for different hospitals around the state of California. We did not do this for some of the other 13 states in which we are located. However, we were amazed at how the phone rang with paranoid outbursts asking why we wanted those reports.

The other cold reality I learned was that one-third of the medical staff was for emergency medicine because it was good for patients and patient care, one third didn't care because all they were interested in were their offices, and one-third was against the concept of emergency medicine because they were worried about bright doctors in the emergency department losing money and their patients. We soon learned how to squelch the loudest doctors on the medical staff who were against emergency medicine by again utilizing the Freedom of Information Act to obtain these doctors' Medicare customary-and-prevailing charges. It was a truth serum that wound up being a pacifier. Many of the loudest doctors objecting to emergency medicine also had some of the highest profiles.

I strongly urge you to involve your entire medical staff in marketing. I did this accidentally after obtaining the hospital cost reports and the Medicare customary charges. I had the following episode involve the medical staff in marketing. Dr. Neurosurgeon walked into the Emergency Department one day and said, "You guys are doing a great job bringing the ambulances in here." He was in between cases. And I said, "Well, thank you, Dr. Neurosurgeon, but the rest of the emergency physicians and I have been out talking to Rotary, Kiwanis, Elks, Exchange, Grey Panthers, Hell's Angels, and we've been training paramedics, EMT's, etc. However, Dr. Neurosurgeon, look at this Medicare customary charge printout of some of the doctors on the staff. We emergency physicians are educating EMT's and paramedics and getting more and more ambulances coming to our hospital. We also are serving good pizza, good coffee and have very attractive nurses in the department. However, in addition to all of the free time I am contributing in education, marketing, public relations, etc., I am going to make \$65.00 when a patient comes in with a metal pipe impaled through his or her head. However, look at this, you're going to make \$2,000, the anesthesiologist is going to make \$400 and the hospital is going to make \$10,000 and the patient is going to die anyway." And I said, "Therefore, we are all going to market together."

We involved the entire medical staff in giving talks and providing education to both the public and various paraprofessionals. The only people we couldn't get to market were the radiologists, because they were all at lunch at the same time together and left the hospital at 3:00pm. We also began to establish the concept of unilateral free care. Emergency physicians across this country have been doing lots of free care and not charging for it. For example, we are the nocturnal, evening and weekend radiologists. We are beginning to charge for that service. You cannot believe how the radiologists' coverage expands to 9:00pm in the evening, six to seven days a week when we begin to charge for interpreting x-rays on a preliminary basis when they're not around. In addition, we've been reading EKG's. The cardiologists read them seven hours later and send the bill to the patient's probate because the patient died. What's the sense of reading EKG's when the patients are alive and not charging for it, and having the cardiologist read the EKG's and be paid for it when the patient is dead. It's not fair, it's not reality and it will no longer be tolerated. We in emergency medicine expect to be paid for the services we perform like any other physician at the time we perform them. We do not expect the radiologists, cardiologists and pathologists to retrospectively interpret under an obligatory consultation for quality control reasons. These numbers have no relationship to patients because they are acquired after the fact. So we are beginning to charge for preliminary interpretation of EKG's and x-rays. And we've told the radiologists and the cardiologists that we would be happy to have them read them when the patient is in the emergency department. For 15 years we responded to code-blues in the hospital and saw patients who were restless and unstable and we didn't charge. Well those days are pretty much over because emergency physicians now have a new gig. It's called charging for what we do, charging for the responsibility assumed, charging like any other doctor and demanding parity and equity for emergency physicians and emergency patients.

If other physicians and the administrators don't wish to recognize us as peers and pay us on a parity basis, then we will change our stripes and buy a piece of dirt and put up one of our freestanding facilities. If we are not treated fairly as collaborators with you, we will become competitors with you. Therefore, I urge you to develop a milieu in your hospital emergency department that is fair, equitable and will provide the ambience for the best and the brightest physicians to commit to emergency medicine at your institution for a career. It is in the best interest of both the institution and patient to provide care by bright physicians at the time of greatest need.

There are many changes occurring in health care delivery and some of them scare even me. I want to relate to you an experience I had recently. Our group of 220 physicians and 40 support staff was approached by: (1) two proprietary hospital chains; (2) a chain operated by a religious order (i.e., the original hospital proprietary chain that just kept it quiet); (3) two venture capital firms, one of which wanted to throw approximately \$10 million our way; (4) a Wall Street brokerage house; (5) a major pharmaceutical company; and (6) a retail merchandising company. They were all interested in obtaining an equity position in some kind of mutual venture to build freestanding facilities. I found it a little scary. However, who knows how the health care delivery system will be structured in the future. One thing I feel certain of, it will not remain the same. For the first time in history, decisions on expenditures for health care are sitting on the desks of the chief executive officers of the Fortune 500 companies. They are angry with us because we are costing them too much money and they're not sure they're getting their money's worth.

Now I want to show you a series of slides on emergency medicine because emergency medicine in many of your hospitals is not yet solved. Some of you right this moment have \$22 and \$25/hour doctors seeing your patients in your institutions. Many of you think you're making money off the professional component. Many of you are doing it at the enormous price of injuring patients and a lousy public relations image in your community. Many of you have rotating housestaff seeing your patients in the emergency department because the various department chiefs tell you that it is important for the housestaff to learn how to take care of emergency patients though it may be at the price of injuring some of the patients. You really believe that you can rotate young doctors through seeing the sickest patients in the community and just when they begin to have some expertise, you transfer them out to another department. That's called teaching hospitals. Once again, at what human price? What medical-legal price? What risk management price? What public relations and marketing price to your entire institution? Folks, emergency services are essential.

Freestandards are just a gimmick in convenience lower cost medicine that's good for patients because they can deliver care at half the cost in half the time with a smile. So I am going to show you how I can attract 50% of the patients that are coming to your emergency department. And if that doesn't sound bad enough, that 50% will represent 80% of the people who can pay you for that emergency department service. Remember, in the freestandards we're only going to take

paying patients. The tragedy of all this is that emergency medicine is an essential one for humanity and that many of your emergency services are still a facade to the public. Many of you joke in your emergency departments about making money not only from Part A Medicare but also from the Part B professional component. And you're buying and putting forth to the public the least expensive physician care you can get to treat the sickest patients in your communities. Some of you don't know what life is all about.

Well, let's get back to basics. What's an emergency? An emergency is an unforeseen set of circumstances that the patient decides requires medical attention on an unscheduled basis. It has nothing to do with what the absentee landlord chief of surgery defines as an emergency... it's what the patient defines as an emergency. And that is the only definition of an emergency, what the patient says it is.

What's an emergency physician? Well I'll tell you what I think an emergency physician is. Needless to say I have a strong vested and biased interest in emergency medicine. However, I think an emergency physician is someone who is going to be able to diagnose my atypical chest pain when I come into the Emergency Department, and not send me home to die because he or she is a rookie who cannot make it elsewhere or is just starting out. An emergency physician is an acute care diagnostician and short-term therapeutic interventionist. It is my opinion that an emergency physician is not worth a damn in terms of competency and experience until he has seen 30-40,000 patients in his/her career.

And, thus, those of you who are jeopardizing the public for all kinds of reasons including financial, turf, status, politics and holy mother education by rotating your interns and PGY-1's through just don't know what it's all about. When I have to deal with you, the way I solve it is to invite you into the emergency department. I want you to listen to the screams, see the blood, smell the vomit, see the faces and generally hang around for awhile. And then I say, "How would you like you wife, your loved-ones, your children, you to be treated in this environment by those kind of doctors?"

Emergency medicine is still unfortunately in some areas a dirty little corner of academic medicine. And the academic impediments to improving it are herculean! They involve disruption of turf. Emergency medicine is a specialty started out in community hospitals, not teaching hospitals because all of you had all that cheap labor running around.

Well, what exactly is your product? I believe you need that marketing research feedback from your community and from society to see whether the products you are producing make any sense in today's society. Just because you can produce a lot of general surgeons doesn't mean you should be doing it. We as an industry don't have a divine right to receive 10% of the gross national product.

Let me now begin with the slides.

SLIDE: In an emergency there used to be nowhere else to go but the emergency department of the nearby hospital. The patients had no choice. The hospital emergency department was the place to go when the doctors' offices were closed. Now there is an elsewhere, at least for a certain group of people with a positive wallet biopsy. Emergency departments must see anyone at anytime. There must be for decency and humanitarian reasons one portal of entry into the health care system that is not completely biased by a wallet biopsy. That's the emergency department. However, we know today that very few hospitals and very few physicians do much charity work. In 1965 almost every doctor I knew had a half a day or one day clinic at the local county hospital. They did it pridefully. It was part of the self-actualization of being a physician. The bureaucratization of reimbursement has despiritualized and dehumanized much of today's medical environment. Some of your chief financial officers look at health care as they would hoola-hoops and hamburgers. It's not the same. Yes, health care is clearly a business, but it's much, much more. Health care is an art, a science and a business all of which must be kept in harmony and balance. The emergency department is the department of available medicine.

SLIDE: As you can see, only three to seven percent of the patients presenting to the emergency department have diseases that threaten life or limb. Thus, out of 88 million emergency department patients, only about five percent are real emergencies. This means 4.5 million human beings are going to have the time of their greatest need for health care in the next year and most will be coming to your emergency department. It better be good. Their lives depend upon it. In my opinion, one could close half the emergency departments in this country and the quality would improve, costs would go down, and everybody would be happier. Perhaps some of you would be making a societal contribution by closing your hospital emergency department. Perhaps you should close your hospital.

SLIDE. Another 10% of emergency patients need immediate attention. Now if there is about 15% who need either "emergent" or "immediate" attention, and an additional 35% who are "urgent" then 50% of the patients or about 44 million can wait for their care. Let's face it, many diseases get better in spite of us not because of us. Why have we in health care not provided a system to deliver unscheduled care? The academicians told us it was supposed to be a close, intimate doctor-patient relationship. Well, a lot of people don't want a doctor-patient relationship because they're healthy. They're 30 years old. They do just fine without us, and say "thank you but no thank you." They don't want to pay the price of establishing baseline blood chemistries for posterity.

SLIDE: Scheduled care never meant anything binding to the physician or your outpatient facilities. The doctor can always be excused because of emergencies, delays in surgery, etc. The population at large, however, gets a little irritated. They say, "Hey, wait a minute. Time is my ultimate spiritual commodity." Think about it.

A system that disrespects patient time may well be perceived as disrespecting other aspects of their personhood. For example, what's the in and out time or the through-put time in your emergency department? I'm going to show you a facility where the through-put time in our freestanding facility is 42 minutes. In our hospital-based emergency department, we work like crazy trying to get through-put times down to 68-72 minutes. Many times we simply are not successful. And yet today, at this moment, many of your hospitals still have two to three hours waits even before the physician begins with the patient. I love it! Because when we look around to set up a freestanding facility, the Fischer-Mangold Group analyzes the hospital emergency department in the area in question. And one of the things we study is the waiting time in that emergency department. Other parameters, of course, are demography, population, income levels, age, geographic distribution, specialty distribution, traffic counts, etc. If you have a service area of at least 50,000 population and a three hour waiting time in your emergency department, you are a target. We, by setting up a freestanding facility, can take away half your patients and 80% of your paying patients because they really don't need your emergency department.

SLIDE: Be concerned about your hospital public (community) relations, if you're worrying about survival. For every patient that comes into the emergency department, 2.6 additional people will come into that department. If you have a 50,000 patient emergency department, that means another 130,000 people or a total of 180,000 human beings will get an impression of your emergency department and of your entire hospital by what you show them in the emergency department. Remember, only 10% of that 50% or 5,000 patients are going to get into your hospital. Even if all their friends come, they're still only 10% of 180,000. Are you putting your best foot forward? Remember you only have one chance to make a first impression. No wonder most of your hospitals are a public relations disaster. The vast majority of people that come to your emergency department and the vast majority of people from your community will see your emergency department as evidence of the quality of your hospital. They are simply not going to get into your hospital. They are not going to see all the fancy-Dan high technology equipment that you have upstairs. They are only going to see your emergency department. Therefore, many of you have public relations disasters or community inter-relations disasters.

In addition to the 2.6 people that come with every patient, every person who is a patient in the emergency department talks to eight people about their visit. It's been 21 years since the concept of career-oriented emergency medicine began and from a marketing and public relations standpoint, most of you have a lot of catching up to do. What are you waiting for? Some of you are slugs, slow-moving slugs. The health care industry is in a revolution and some of you are sitting ducks.

If you haven't spent a night in the last six months in your emergency department to see what is going on, you're not doing your job. You're supposed to be the policy makers, the spokespersons. You are supposed to understand the gestalt, the feelings and nuances of your institution.

Do you? How many of you have spent more than three or four hours in your emergency department...after midnight I mean!? My congratulations and respect and admiration to those of you who raised your hands.

How many of you do patient satisfaction studies? In how many of your institutions is every patient called via telephone the next day? That is what we do in our freestanding facilities? We even have the physicians speak to some of the patients. In our contract emergency departments we encourage our emergency physicians to call at least five people that were seen the previous day, and have set up a system in our hospital-based units for nurses to call the patients the next day. Patients are incredibly impressed when a doctor or a nurse calls and asks, "How are you doing? What does your arm feel like? Were you able to make an appointment with your doctor? Do you have any questions on how to take the medicines? Etc? Etc? " The patients are stunned...It is wonderful public relations. It is wonderful marketing. It is caring.

We are growing in our hospital-based emergency departments. Last year, our emergency departments grew at a rate of 12% annually. Our group contracted with 35 hospitals, we see almost 900,000 patients and we have more than 200 fulltime career emergency physicians. The average age in our emergency physician group is 38 years old and the turnover rate in the last four years has averaged four percent per year. Some of you cannot keep quality emergency physicians because they have no incentive to stay, no status, no recognition, no clout on the medical staff and no financial incentive. Others of you are doing a wonderful job to provide a solid financial and career opportunity for the best and the brightest physicians to commit to emergency medicine. Does your medical staff want the best and the brightest physicians in the emergency department? Some medical staffs do, but many want "boys" down there. Any many of you CEO's listen to the big daddies of the old boy network of your hospital. You place in the emergency department compliant and nonthreatening emergency physicians because your medical staff is worried about losing money and losing patients, rather than worrying about providing patients with the best and the brightest physicians possible to meet their human and medical needs.

If the best and the brightest physicians are in the front line in the emergency department we could decrease societal health care costs dramatically, because we are the gatekeepers. We don't make any money when we admit patients. You as the hospital administrator, the medical staff and the institution make the money. If we had the best and the brightest physicians on the front line seeing the sickest patients 24 hours a day, doing histories and physicals and appropriate workups. we could decrease the number of patients admitted into America's hospitals substantially. And that is good for society.

Do you think the health care insurance industry has a vested interest in decreasing premiums? Decreasing revenues? Nonsense. They get a percentage of the action. The only time the medical insurance industry or the health care industry is interested in decreasing the premium is when public outrage threatens loss of the entire premium. Then they're very interested. Well, that's happened, folks. Now everybody is

interested in decreasing those premiums. Who has the incentive to decrease the money coming into medicine? Well, probably none of us in the room, but certainly the waiter who served you lunch and the employer of the waiter who served you lunch, and that's about it.

SLIDE: This next slide is intended to demonstrate that patients want to be seen for their medical reasons before the hospital fulfills its needs and requirements for paperwork. Those of you that register patients in your emergency department before we the clinicians, doctors and nurses have a chance to see them are absolutely wrong. What you are saying to the patient is, "My needs as a hospital administrator and the needs of the institution are more important than your human needs. Therefore, I will get my needs for paperwork done before you get your health care needs attended to."

You and I as patients want to be seen by doctors and nurses who give a damn. Since being in the freestanding ambulatory care management arena, I have acquired a tremendous respect for those of you that put together real top-notch organizations and quality teams because I have also gained an increasing respect for the difficulties in putting such a team together.

SLIDE: Those of you who still have moonlighters such as depicted on this slide, or young doctors right out of residencies are not fulfilling for the emergency patient your societal obligations. Those of you who are still rotating the ear, nose and throat doctor through the emergency department are injuring patients, no question about it. Those of you who are paying doctors on a salary are getting exactly what you deserve because human beings are usually incentive-based. Physicians are highly motivated but they also know when they are being exploited. And yes, they'll take it for a little while but the resentments will build up because their needs are not being fulfilled and their pain accumulates. Many of you by exploiting emergency physicians are building a group of physicians who will get even with you someday. Clearly I'm an entrepreneur and I believe in incentives. I also believe that many of your hospitals would be better run, more efficient, more fiscally well if you, the CEO, were incentive-based. If your compensation was based upon bottom line performance, reputation and quality of care, I think all of you would do better. A hospital administrator once told me fee-for-service was an evil. That man is either afraid of competition, or afraid of new ideas, creativity and risk-taking. That person may also be afraid of losing his job and clearly does not understand human nature, values and the thrill of victory and the agony of defeat. There is no such thing as the status quo. I don't feel that fee-for-service is necessarily the end all and be all, but I do care about incentives.

SLIDE: This slide clearly shows that patients want to be seen by courteous people. This discourteous nurse could also be the physician or the administrator or the clerk. Patients want to be seen rapidly, competently and courteously in the emergency department. They want their time and dignity respected, and their bodies competently invaded.

SLIDE: Gross revenues clearly do not come about as a result of gross charges. But so what? So, hospital emergency departments have some bad debt. Big deal! They fill your bed and they utilize your ancillary services and that's where the profit margin is.

SLIDE: The accounting department -- all kinds of things can go on in your accounting department. If your emergency department is costing you money, my recommendation is that you close it. I really mean it. As I stated previously, I think this society should close some of its hospitals and certainly some of its emergency departments. I do not know much about global hospital economics, but I know a fair amount about emergency departments and if I were the Czar I would close 30-40% of them right now. The quality of care would improve and think about the cost to and the savings for society. Who is thinking about societal interest in health care? If not you, who's going to do it? If not now, when? And don't think the politicians are going to do anything but serve themselves first. They respond to public opinion as we in the hospital and health care industry soon will. Why do hospitals frenetically open up emergency departments? Well, they do it to fill their beds. You know it and I know it. This slide shows who made those decisions. They're called the board of trustees.

SLIDE: The next slide shows planners. I love this slide. Health care planners, comprehensive health care planners, HR-1, etc, etc. Well, in my experience I'll tell you what I found planners to be. A planner is a 26-year old person who has a master's degree in health-something-or-other, can't get a job in the industry and all of a sudden is the regulator for the entire industry. That's my experience with planners. What a joke!

SLIDE: Here's another slide for you doctors in the crowd. What's this diagnosis? A burn, right? That's right. Now make believe you're an emergency physician. This patient came into the emergency department. Now, what's the diagnosis? (Audience participation, "Scalded skin.") Well, let me tell you something, folks, it's scalded skin alright, but by sending that baby home with treatment of a burn you have perhaps killed that baby because circumferential burns in a child is child abuse until proven otherwise. This happens to be a case of mine and that indeed is what the etiology of this circumferential burn was. Now today many of your housestaff officers are seeing burns in children just like this. And they will send these patients home treating the burn well and correctly. They will also see some of these children back in a week or a month or a year with a depressed skull fracture. Some of them will die, some will be mentally retarded and certainly all will be psychologically scarred for life. Medicine is very complex and there are many subtleties that can be dealt with in a very low cost but efficient manner.

SLIDE: OK, this slide shows that you are the fat cats. You are the king pins of this health care delivery system. You are the CEO's of teaching hospitals. You are supposed to be the best that there is. You have the obligation for staying creative, and clearly the purpose of this talk is to be a provocateur and get you thinking about getting ready for future competition.

SLIDE: This is our freestanding facility in Reading, California. This is the waiting area; it's too large, people don't wait. People come in, we register them, get their names and put them into clinical rooms.

SLIDE: This is the registration area. It has privacy. For example, how many of you would come into your own hospital and say, "I think I have a hernia." If you do that, we all think you have gonorrhea. If you said that as you stood up in the corridor and talked through a hole in a piece of glass, maybe your neighbor would hear you. If the registration of the patient is not private, at least auditorily if not visually private, middle class paying patients will not come to your facility.

SLIDE: Time expands under pressure. Those of you who don't have cluster seating and mirrors in your emergency department to help time contract are just generating complaints. Mirrors in the department get people to become introspective. Time contracts under introspection. Those of you with red in your emergency department waiting area are just asking for trouble. Red excites. Blue is the color; pastels, subdued, calming, supportive. Those of you that have noisy emergency departments are asking for trouble and are generating complaints.

Remember, guys like me have options on pieces of dirt in your town. Our own group has six options and one of them may be in your neighborhood. I'm not going to tell you which towns they're in, but remember there are crazier guys than me out there.

SLIDE: This is what the building looks like from the outside. X-ray is very important. X-ray is a financial slot machine, much better than going to Las Vegas.

SLIDE: Our Dr. Welby is here! Kind, caring, experienced and supportive. That's the model doctor for a freestanding facility. Remember in these facilities there are no x-ray delays, no lab delays, no CCU delays, no cardiopulmonary resuscitation in progress, no multiple gunshot victims coming in to slow down the care. The nurses and the technicians are never at lunch at the same time. The environment is pleasant, it is less expensive, it has far less regulation and therefore lower costs, and is far less emotionally traumatic.

SLIDE: Well, the cost of these facilities can be approximately \$250,000 if opened up in leased space in a shopping center, and between \$500-750,000 if one builds one's own facility, buys the land and builds the structure.

SLIDE: This last slide contains the punch line. In the last three years the cost per patient in this freestanding facility has been \$40.40. That is total cost per patient, including doctor's fee, lab, crutches, EKG, splints, ace wraps, etc. Remember, this is boring medicine. However, compare this \$40.40 to patients seen in the hospital emergency department in the same town. You'll find that if these patients went to the hospital emergency department, the average fee would be \$84.00.

Now those of you who have teaching hospitals, and I guess that's all of you in the audience, you have a 50% teaching premium. So, I can deliver in Reading, California for \$40.40 what you can deliver for \$126.00. And remember, I can do it twice as fast as you can in your teaching hospital, probably much more courteously and just as competently, if not more so because I have experienced physicians, not rotating housestaff officers whose expertise varies. Is this freestanding facility good for the society? You betcha! And it would be societally cost effective to close half the hospital emergency departments, so our facilities won't be societally cost additive.

Finally, I want to close with a little philosophy. It is taken from a book called The Leader. By now some of you must be writhing under the old accusations of being ivory towers, although personally I find a tremendous variation in your mission within this audience. However, some of these accusations must hurt. You've been called ivory towers, unresponsive to human needs, insensitive to patients... not by design but by behavior, excessively expensive and concerned primarily with your representation among the self-appointed medically elite. On the other hand, some of you love it, don't you?

This year, 1982, is the time for medical statesmen. I mean that seriously. Now is the time for statespeople as opposed to medical politicians. Now is the time for difficult decision-making. Perhaps even closing some teaching hospitals or decreasing the number of teaching assistants, telling the superstar chief of staff that he is wrong and behind the times and myopic and overspecialized. Some teaching hospitals were established primarily to increase the per diem rates. Some of you are a joke. Some of you are a disaster in that your teaching hospital was established so that you medical staff wouldn't have to get up at night and see patients. What that does is guarantee that five years later your medical staff can't take care of sick patients anymore even if they wanted to. Now is the time to look for systems failures to try to prevent their recurrence in the future. Now is the time to obtain realistic, meaningful and timely feedback mechanisms regarding the applicability of your health care products to the needs of the society. I don't think U.S. teaching hospitals met society's needs for emergency medical services very well. From my perspective, it was forced down your throat through embarrassment. And you're supposed to be the leaders. Now is the time for you constantly to be looking at the bigger picture. When you think you understand the picture, there is always a bigger one.

The leadership and the responsibility that each of you bring to your institution, the innovation, the risk-taking, the maturity and the ability to attract and retain honest, competent people around you will be your contribution to medicine and society, and to your institution. Those of you who obtained your positions by virtue of a high degree of intellectual achievement, but also obtained them by the use of fear, domination, manipulation and gamesmanship are in for rough times. These times don't need game players. The stakes are too high to be left in your hands. The leaders of today require a high degree of vulnerability, openness, collaboration and a willingness to fail

because the old ways won't work. The governmental printing press has been cut off. The bureaucracy that made a living by lamenting over the needs of the poor is going to be out of a job. A better way to care for the poor must be found. It must be societally responsible.

Yes indeed, the role of leadership has become very, very specialized. Leaders today are required to be persuasive communicators. They all share critical attitudes toward traditional authority. You have to be able to go home and look in the mirror, be honest with yourself and talk to yourself about what you're really doing, what's your real motivation and what's the real degree of your performance.

The majority of you won't have the guts to look in the mirror and talk to yourself when nobody is around. In my opinion, the most regal among you are the institutional royalists who have the willingness to take risks, to experiment with the new social order for the sake of humane goals. Stop advocating the quick technological, scientific fix. Today's technology is tomorrow's malpractice. We as an industry and maybe as a nation are enamored with expensive gadgets. Effective leaders today are caring respectful and responsible. They're flexible people. They are willing to share power. They understand that the way to gain and maintain power is to empower other people. They are good stewards of other people's money, and that is the most difficult thing to be. Good leaders function in an area of trust. They invite criticism and are not afraid of taking an unpopular position. They willingly assert authority on the issues and matters of principles, which gives them the security to make compromises.

The negotiating strategy of the winners in the 80's will be win/win scenarios. A win/win scenario is objective, fair, longterm and quantifiable. A win/win scenario is easy on people and tough on issues. It requires creativity to develop win/win scenarios while a win/lose scenario requires no humanity and no brains.

Negative energy is very exhausting and non-nurturing. I encourage you to go back to your institutions and make them lean and supportive. In most organizations, the minority make it happen anyway. Go for quality instead of quantity. Support your people constantly and the best leaders will be the ones who help people until eventually they don't need you at all.

I want you to think about one more thing. I believe some of you may even have enough guts to analyze one of the real damaging sacred cows in American medicine, namely the quality, qualifications and performance of your hospital's board of trustees. Who sits on the board of trustees? They're white and upper middle/upper class. They don't have to take any examinations or conform to any criteria. Members of America's boards of trustees are there through power, influence, nepotism, philanthropy and just about everything else but knowledge. It's ridiculous that an industry of this import vests its authority in people who clearly have not demonstrated a knowledge base.

Closer scrutiny of this factor is in order. As a reward for those of you who are the risk-takers, I leave you with this base of philosophy. It was Machiavelli who said, and I'll read this exactly, " There is nothing more difficult to take in hand, more perilous to conduct or more uncertain in its success than to take the lead in the introduction of a new order of things, because the innovator has for enemies all those who have done well under the old conditions and lukewarm defenders in those who think they will do well under the new."

It has been one hell of a privilege and fun experience to get all you big hitters to listen to me on these philosophies, ideas, concerns and issues. I have a great deal of respect for many of you and have enjoyed the opportunity to address this group.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"COMPETITION CONFRONTING UNIVERSITY HOSPITALS: ITS IMPACT ON PATTERNS OF GOVERNANCE"

Presentation by Fred Munson, PhD

That's kind of a hard act to follow. Our research, which was funded by the Consortium for the Study of University Hospitals, focused on the management and governance of these hospitals. It makes use of available data such as COTH annual surveys, field studies that we conducted in 16 hospitals and a special questionnaire which will be mailed to all university hospitals shortly.

The field study hospitals themselves are the ones listed in Slide 1. We tried to select them so that there would be substantial diversity in the kind of governance that they had, the size of indigent populations they served, the kind of medical school, and other points which we thought might be relevant to governance. You will notice that one of them is not a university hospital; Johns Hopkins Hospital is a separately owned corporation.

We talked to over a dozen people in each of these hospitals. This included hospital administration officials, medical school deans and administrators and university administrators and community personnel, also regulatory and state officials.

Fundamentally all teaching hospitals face similar challenges in securing dollars which in some respects takes precedence over securing patients, and securing approvals. These are the three critical parts of any teaching hospital's environment.

We think of this as the external environment of the hospitals that are the focus of our study. And in this respect university hospitals are not different from other teaching hospitals. University hospitals, however, operate in a setting that both helps and hinders them in responding to the challenges of securing patients, dollars and approvals. They receive dollars from the state but in return are subject to a measure of control from the state. They receive services from the university and in return are subject to a measure of control from the university.

They receive important resources from the medical school, both prestige and direct medical resources, but in return receive a measure of control from the medical school. And we think of this, what we call the in-law battle, we think of this as the local environment in which university hospitals operate, and we think of it also as the distinctive difference that gives a uniqueness to university hospitals as a subset of the larger set of teaching hospitals.

The support, the services, the prestige, the resources received really give university hospitals a cushion. They are in that respect somewhat better off than other kinds of teaching hospitals. But the control from these groups that really feel a kind of ownership right and an ownership obligation for the university hospitals produces inefficiencies and certain kinds of organizational incapacities. When times are good, as they were for a substantial period after the Second World War, really no one cares. But when times are bad, this control threatens the viability of the university hospitals.

We also have to accept the possibility that, when times are very bad, the support from the state and from the university may in fact mean the survival of the university hospital.

This set of organizing ideas is summarized in our study framework here in Slide 2. Fundamentally we're saying, if we start at the hospital, a hospital has a set of outcomes, outcomes that have to do with contribution to education and research, with patient care, with economic performance. The ability to achieve these outcomes is influenced by the governance of the hospital. Governance really is the group or the process which mediates the influences from the local environment, and is also the process which directs the responses to the pressures from the external environment.

The basic framework of our study is to understand the impact of the local environment in helping or hurting the university hospitals' capacity to respond to its larger environment which it shares with other teaching hospitals. I would like to discuss today just illustratively one set of observations. Those observations deal specifically with one dimension of the hospital, its internal structural clarity with one measure of effectiveness, performance viability, one of the economic performance dimensions.

The dimension of internal structural clarity is made up of two components, a clear executive leader role and a clear decision structure. The information for these soft indices come from the interviews which were conducted in the 16 study hospitals. In each case we gave hospitals a scale value on these two components, usually on a four point scale, and we checked among ourselves, among the research group and assigned values and then formed an index of these two components we called internal structural clarity.

We would expect this variable to predict to a variable we call hospital viability. Hospital viability is made up of three components. These are: 1) operating margin over net revenues, 2) the times interest earned ratio which is simply the interest payments plus the operating margin divided by interest payments, and 3) the occupancy rate. We used these three to index hospital viability. These are the only two indices that I will use today.

One of the issues that we can address is how close the relation is between the structural clarity of these hospitals that we looked at and their viability. Now, you will see in Slide 3 that there is something of a relation. It is not a strong one, but in general hospitals with high structural clarity to the far left are associated with higher levels of viability. But it is not an impressive relation; it is not in fact a statistically significant one.

The relation by any definition is weak, and we can investigate this weakness by looking at some of the prior elements in our study framework. Specifically, when we say prior elements, we're saying that the effectiveness of the hospital is in part due to its internal structural clarity which can produce viability, but if this relation is a weak one, we can look backward at governance, at the local environment or the external environment.

I want to touch only briefly on some of the factors in the local environment. It was possible for us to look at our study hospitals and rate them according to the degree to which they were penetrated by their local environment, the degree to which the hospital was controlled by the state, controlled by the medical school, controlled by the university. This measure is an index that is made up of six components shown in Slide 4. These are: 1) strong university regents, 2) autonomy of the hospital from the state, 3) autonomy of the hospital from the university, 4) medical school prestige, 5) the influence of the chiefs and 6) dependence on state appropriation.

Think of this index as the degree of penetration, or conversely protection, that the hospital has from its local environment. Now I should like to go back to Slide 3.

You'll note that there are both boxed dots and circles. Look first at the circles. These are the hospitals which were most penetrated by their local environment. The boxes are the ones that are least penetrated, that have the highest autonomy.

If you look first at the circles, you will see that only two of the seven have high to medium clarity; that is, five of the seven tend to be to the far right, and only two of the seven have high clarity. As the penetration of the hospital increases, it becomes increasingly difficult to have clear leader roles or clear decision structures. There are too many cooks, and it spoils the broth.

By contrast only two of the seven hospitals with low penetration did not have high or medium clarity; that is, as you look at the boxes, you'll find that five of them are on the far left, the high or medium structural clarity.

Secondly, as you look at the circles again, notice that the relation between viability and internal structural clarity is weak; that is, there is almost no visible float as you move from left to right down the graph. As you look at the boxed hospitals, the ones that have relatively high autonomy, you find a much sharper relation between high viability, high structural clarity on the one hand and low-low on the other. As the hospital increases its autonomy from its local environment, you have the opportunity then to have increased viability.

Finally, with respect to the highly penetrated hospitals, notice that none of the hospitals have low viability. The protection seems to show up even in this rather limited sample. They are domesticated. The (✓) marks on the graph identify those hospitals receiving the highest proportion of their revenues from state appropriations. You will note that all save one are the protected, or penetrated hospitals. These hospitals are, so to speak, cared for. Their viability is not at issue.

You can say that the high protection hospitals don't do very well; the highest viability hospitals are also the most autonomous. But the protected hospitals don't do very badly. The three hospitals lowest in viability are also the autonomous hospitals. So the point that I want to emphasize is that our research so far does not show clear and persuasive relations on a single dimension; that is, we cannot say that the more autonomy you have from your local environment, the better off you are.

What seems to be more clear is that the more autonomy you have, the easier it is to do well or do badly, but it's more up to the hospitals and their external environment. The hospitals with high autonomy as opposed to high penetration have a much greater range of viability, and the relation to structural clarity is much stronger.

Can strong independent governance help? Logic says it should, but our study so far suggests that it is in the short run at least as much an outcome as it is a cause. That is, effective leadership can produce independent governance, just as it can produce high viability. This is how a university chief financial officer answered when one of the members of our team asked how the hospital board in his hospital was formed.

"I think just at the recommendation of the hospital. I assume that our hospital CEO woke up one morning and decided that all his colleagues in the hospital association were going to have, were going to independent boards, and he decided he'd better start working on one here. And I have no doubt that he conceived the idea and kept working on it over a period of years until it came about."

Now, what is being said here is not that this independent hospital board was unimportant, but that it was an outcome of a strong executive, strong leadership decision. In a short run analysis, our evidence to date tells us more about what causes hospital governing boards than what they cause.

The long run effect is a very different question, and one that is much more important. Our present feeling is that university hospitals are in some cases not truly organizations. They are facilities that different groups seek to use for their own purposes. We think it possible that competition, competition for patients, competition for dollars and competition for approvals will drive such hospitals toward fuller domestication, becoming wards of the state, or toward fuller independence, able to compete in the health care marketplace. For the latter a clear focal point for governance decisions will be necessary. It need not be an independent hospital board, but the advantage of an independent hospital board is that it gives that strong focal point, and makes it independent of persons. We will need data from all university hospitals to investigate this, not just the 16 that we have, and the survey which I spoke of early will be going out towards the end of this month or early in June. We hope all university hospital CEOs will cooperate in completing it and returning it.

The CSUH is planning to have us present our complete findings in a January 1983 seminar for the field study hospitals and those which are supporting this study.

I should like to close, if you will permit me, with an ancient fable that speaks somewhat to our research focus.

An Ancient Fable

Once upon a time in a faraway land there lived a loosely coupled university hospital system. It did not know it was a system, because the many persons who lived within it were so loosely coupled.

The state's 2nd assistant director of personnel for non-professional occupations ordered the promotion and transfer and job upgrading policy for all state employees (including the state university hospitals), the university's manager of parking operations allocated stickers to staff, and capital to parking structure construction (including the hospital's), the regents attended carefully to approving senior appointments for all the campuses under their control (including the hospital's), and the president of the university attended carefully to its core teaching and research purposes, making sure that such service functions as the book store, the hospital, and the dormitories supported these services effectively. None of them knew the boundaries of their system, they were so loosely coupled.

The hospital administrator swore at the 2nd assistant director of personnel for non-professional occupations, he cursed the university parking manager, and reviled (though softly) the regents and the president. Sometimes the Dean of Medicine swore, cursed, and reviled with him, when he was not busy with more important matters. More often, the clinical chiefs would swear, curse, and revile with him, they less often having more important matters--for the hospital was their home.

They would often gather to curse and revile the 2nd assistant personnel director for making it difficult to provide good support services in the hospital by requiring stupid rules for appointing admission clerks or upgrading laboratory technicians. At such times the hospital administrator would not speak of the clinical chief's absurd practice of having clinical staff (on which the fame of the hospital did rest) unavailable for consultation, or of the fact that 90 percent of the care was given by residents. Nor would the clinical chiefs speak of the hospital administrator's endless multiplication of administrative flunkies, nor their ignorance of the true function of the teaching and research site they presumed to administer. Yet such ignorant misconceptions troubled the chiefs, and yet more the Dean, and they silently pledged to see that the hospital would remain true to its purpose.

One day the hospital administrator was away in the great city assailing the dark lords of the cost cap. While he was absent, a meeting was held in which a junior administrator said,

"We have low occupancy (and this is a horrible sin) which is due to the contemptuous attitude of our medical staff to the feelings of referring physicians."

The clinical chiefs, much roth at this irresponsible poaching on their problem domain, said,

"If we have low occupancy (and that is your problem) it is because you have dirty halls, lousy food, an admissions office dedicated to troubling patients, a billing office that can't bill, and a great surfeit of business-suited non-entities. Should we desire your advice on medical matters and appropriate courtesies to our colleagues (which is unlikely) we will ask for it."

The junior administrator was chastened, and the more so when he finished his exit interview with the hospital administrator the following day.

On another occasion the hospital administrator spoke boldly to the Dean and asked,

"Would it not be good that I should assist you in the selection of the chairmen?"

"No", said the Dean, "it would not be good. We know more of these things than you, being familiar both with who is available, and what needs doing. You know something of the outcomes, but nothing of the medicine that makes them possible. Pray leave such minor matters to us, and attend to the large questions of finding nurses, finding space, and other great matters which concern you directly."

On yet a third occasion when the hospital administrator was in a distant city recruiting allies against the evil forces of rate review, another junior administrator asked of the university's chief financial officer,

"Is it necessary that you sequester our cash reserves and deny us the interest that may be gained from them?"

The chief financial officer answered,

"Why do you trouble me with such things? Look rather to containing your endless requests for exceptions, your fault-finding with our procedures, your inability to control your own costs. Remove the beam in your own eye before worrying about the mote of benefit that your university may garner from the hospital."

And after such occasions one could often hear a gnashing of teeth in the administrator's office--and sometimes great wailing.

And so it came to pass one summer morning that the hospital administrator arose and said to his wife,

"I have a dream."

And she said,

"Tell me your dream."

Said the administrator, "I dreamed of a system, clear in mission, united in purpose, and so neatly structured that a good man could run it, and not appear a fool."

"How different," said his wife. "Now drink your milk and be off, for such things are only for dreaming."

But the hospital administrator was enthralled with his idea, and would not leave it. And he gathered others and said,

"Let us assail these problems with our wisdom and with academic research, that we may overcome them."

And because his words were wise, it was so arranged.

Thank you.

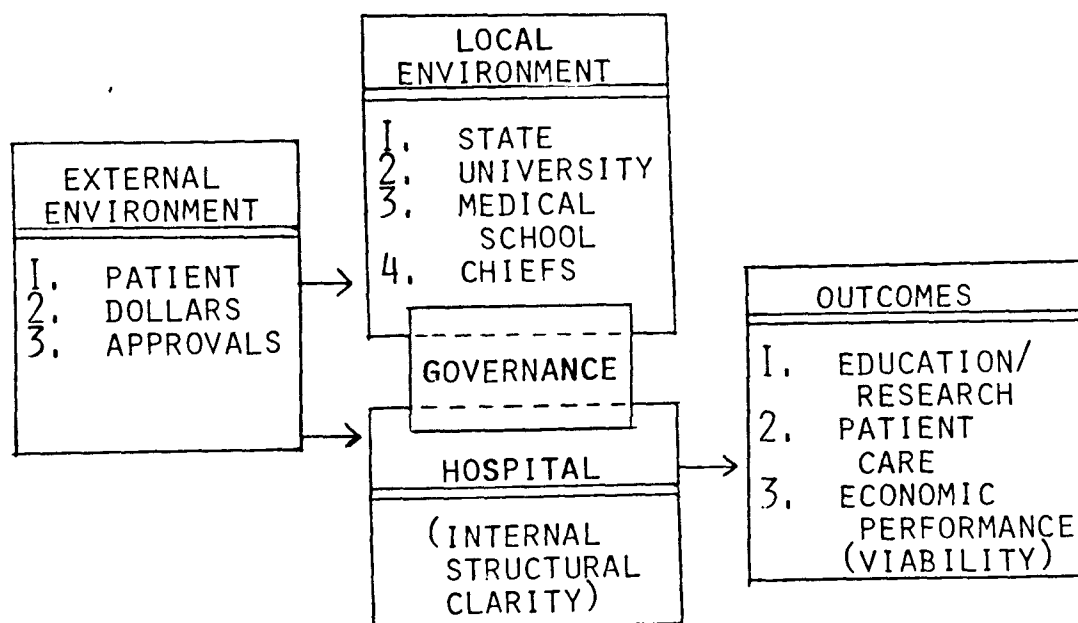
Slide 1

FIELD STUDY
UNIVERSITY HOSPITALS

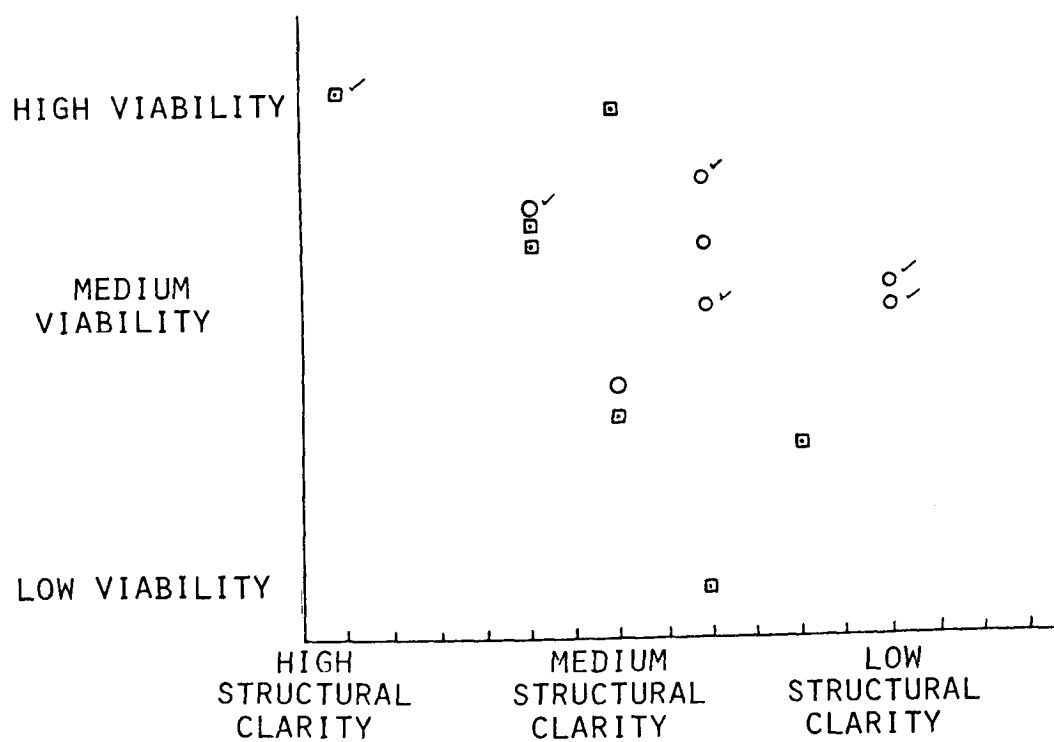
COLORADO	MASSACHUSETTS
FLORIDA	MINNESOTA
IOWA	NEBRASKA
JOHN'S HOPKINS	NORTH CAROLINA
KENTUCKY	OKLAHOMA
UCLA	UNIV. OF ROCHESTER
MICHIGAN	MED. COLL. OF VIRGINIA
UCSF	WASHINGTON

Slide 2

STUDY FRAMEWORK



THE RELATION BETWEEN HOSPITAL
VIABILITY AND INTERNAL STRUCTURAL CLARITY



Slide 4

UNIVERSITY HOSPITAL
LOCAL ENVIRONMENT

AN INDEX MADE UP OF 6 COMPONENTS:

1. STRONG UNIVERSITY REGENTS
2. AUTONOMY OF HOSPITAL FROM STATE
3. AUTONOMY OF HOSPITAL FROM UNIVERSITY
4. MEDICAL SCHOOL PRESTIGE
5. INFLUENCE OF CHIEFS
6. DEPENDENCE ON STATE APPROPRIATIONS



association of american medical colleges

"NOT-FOR-PROFIT CHAIN OPERATIONS: ASSESSING THEIR IMPACT AND LOOKING TO THEIR FUTURE"

Presentation by SCOTT S. PARKER

I appreciate that introduction, and I think that you would understand if I quickly tried to interject a disclaimer about my knowledge of this business of multi-hospital systems. I certainly don't represent the perfect knowledge, though I think I may have some things of interest for you.

But on the subject of perfection, it reminds me of our hospital chaplain down in Newport Beach, a Presbyterian hospital, who told this story. I'm not sure if it's true, but I never had enough courage to challenge him because he was a chaplain.

He talked about the Presbyterian minister who was very concerned about the behavior of his congregation; so concerned that he prepared a stinging sermon on the subject of repentance and delivered it very effectively.

To make his point at the end of the sermon, he asked a question, a rhetorical question, he thought. He said, "Now if anyone here thinks he is perfect, I'd like him to stand up". A fellow right in the middle of the congregation, without reservation at all, stood up quickly, shoulders back, head high, proud look and caught the minister off guard. He wasn't prepared for that.

He finally regained his composure, shuffled his papers and said, "Now, sir, are you really sure you understood the question? Do you think you're perfect?" The fellow said, "Well, no I'm just standing in proxy for my wife's first husband!"

With your understanding, I'll stand in proxy for whoever that fellow is that has the perfect knowledge of not-for-profit multi hospital systems.

I looked carefully at the topic assigned to me -- "Not-for-profit chain operations -- assessing their impact and looking to their future". In a letter that I received outlining this program, I was asked by Dick Knapp to talk about these five things: new indications for growth, multi hospital systems, predict their profile five years from now, suggest the involvement and role of major teaching hospitals with not-for-profit systems, speak to the question raised by Mark Levitan before this group in 1978 regarding some of the hard questions critiquing the theory behind multi hospital systems and finally, compare the operations and objectives of for-profit systems and not-for-profit systems.

I understand that my assignment is to report and predict, not necessarily to sell. I find that very hard; I hope you'll understand. There is no question that I am an advocate for not-for-profit multi hospital systems.

My approach will be to develop my presentation in four parts. Part one will be to briefly document the growth indicators in not-for-profit systems. Part two will be to review the theoretical rationale proposed early by the proponents of multi hospital systems. Part three will be to report on the results of an experience of a sample of one multi hospital system (as you would guess Intermountain Health Care) related to those early theoretical advantages proposed.

And fourth, I will conclude with a prediction as requested regarding what might be developing in the future with the growth and change of not-for-profit multi hospital systems.

Part one: some growth indicators. I use as my statistics today those of the American Hospital Association recently developed for the Association as part of their future planning. I'm talking now about for-profit and non-profit hospitals. In 1950, there were 261 hospitals in systems, in 1979 there were 1500, and in the decade 1970-78, 900 hospitals joined hospital systems. In terms of percentage of beds, in 1965, (round numbers) three percent of the hospitals in the country were part of systems, 1980 - 30%.

My state, which is probably atypical, may have the highest concentration of hospitals in systems. We have only five hospitals in our 47 hospitals in the state that are not part of hospital systems, either for-profit or not-for-profit. There are similar, but not that high, concentrations of hospitals and systems in Arizona, Nevada and Montana. So much for the statistical base. The point is that many hospitals have, are and will join systems.

Now for part two: a review of the arguments used by the early proponents to encourage the development of systems.

First was the ability to respond more effectively to the mounting pressures on cost controls coming from government corporations and other interested parties. Theoretically, hospitals in systems are more able to respond to those pressures through shared services and improved management systems.

Second was the ability to attract management specialists and develop career paths within the organization for hospital managers.

The third advantage was the ability to improve quality through modernization of equipment and facilities, through internal peer review and quality assurance programs and by better coordination and reduced duplication of

clinical services.

The fourth argument was the ability to organize a political profile of stature in order to participate as an equal partner rather than as simply an interested bystander in the political process that affects hospitals.

I've condensed many of the arguments down to those four and I'll respond to each this morning.

These claims have evolved from textbook theory, Monty Brown being one of the most prolific writers on the subject -- to slick and professional advertising used by many of the systems, both for-profit and not-for-profit, to advocate these advantages.

I use, for example, two advertisements from recent publications of Trustee Magazine, an American Hospital Association publication. This one is by Pacific Health Resources, Sam Tibbitt's organization, in Los Angeles. The headline, "The tougher your problems, the more Pacific can help". And then in the beginning the ad states, "governing boards of hospitals everywhere are all too often burdened with the tremendous complexities of hospital finance, management and operational details." In the text they develop an argument that they can help.

Here is one from Fairview Hospital in Minneapolis. "When Princeton Hospital needed help, (that's Princeton, Minnesota by the way) they joined the system that agreed to leave them alone." They make the very strong point here that you can join a system, get all the advantages of a system without conceding all of your autonomy. It is a very effective ad. They also know what drive there is with many small hospitals to join systems and they've tried to combine both in that ad.

Not-for-profit systems are advertising too and I don't raise these examples to be demeaning at all. I have great respect for both of these

were deciding whether they should or shouldn't divest their system of hospitals seven years ago.

In 1975, the LDS Church was faced with a difficult decision: should they or should they not continue to operate their system of 15 hospitals? It was decided that because of the high level of capital expenditures that would be required, all out of church reserves, to improve, build and expand that system - they decided that because the operation of hospitals was not central to the mission of the church, that the community was large enough and strong enough financially to be responsible for their own hospitals. It was concluded that it would be best for the church to divest their hospital system.

These hospitals were in a wholly-owned subsidiary corporation, operated by the church. The balance sheet with all the employees and facilities were turned over in a divestment to a board of trustees, non-paid, non-profit, who then formed Intermountain Health Care, a non-sectarian, voluntary, not-for-profit hospital system. The system included a range of hospitals from the flagship 570-bed teaching hospital in Salt Lake City, down to and including a 15-bed one doctor hospital in the rural Wyoming.

That board of trustees selected a President -- I had the good fortune of being asked to fill that position -- I, in turn, recruited a new management staff.

The church had been in a five-year building moratorium feeling that they shouldn't invest in new facilities or replacements until they had made their final decision about their own future role. As a result we faced tremendous pressures for expansion and construction of new facilities.

In addition to that, we found ourselves in competition with the largest and most effective, from my point of view, for-profit multi-hospital system in the United States, Hospital Corporation of America.

organizations and for their leaders, and I only bring them up today to point out that they are effective, and hospitals are responding. I think that advertising will have an impact and that more hospitals will be joining systems as a result.

Now, I think I need to keep this presentation somewhat balanced, and I feel it necessary at this point to report to you that there have been, are and should be many critics of multi hospital systems, and they have raised some legitimate questions about the proposed advantages that I just reviewed.

I think David Starkwether at Berkeley has probably done the best job in identifying some probing questions about systems. He asks the following:

First, where is the documented evidence of any kind -- pro or con -- that multi hospital systems are meeting the earlier proposed potentials? Second, don't new layers of management and other layers of overhead offset any of the economies of scale? Third, aren't hospitals of 400 beds or larger large enough to attract management specialists, political clout and the economies of scale that are enjoyed by multi hospital systems? And, fourth isn't there real danger in concentrating power and authority over many hospitals in one organization?

Each of us of course, has to reach his own conclusion and judgment regarding these legitimate questions, based on our own observations and our own experience.

Now I'll proceed to respond to those questions based on my own observations and my own experience and reflect those in terms of our organization, Intermountain Health Care.

Earl Frederick is here today. He was part of the consulting team that consulted with the LDS Church, the "Mormon" Church, when they were

They had, the same year the church divested its system, decided that the intermountain area would be one of their priority target areas for their own growth.

And so they came -- well prepared and well financed. We were faced with a very difficult decision during our first year. Would we compete and attempt to hold and improve our "market share", if you will, or would we concede the marketplace to the competitors? Our decision was to compete and over the course of a five-year history of competition, we've had some success in telling our story and proposing the advantage of not-for-profit systems compared to for-profit systems. Now that's not my subject today, that's another talk I'd like to give you some time, but I'll stay away from that except simply to give you a feel for the environment. It has been highly competitive.

At the same time, we've had to do a lot with our own hospitals. We've had 8 ground breakings with \$300 million invested in those facilities over the last seven years.

Now what I'd like to do next is to go back and talk specifically about those four proposed advantages of multi-hospital systems, not-for-profit, and put them in the context of our own experience.

First, on the subject of costs, our record is favorable, in spite of this significant investment that I just mentioned -- nearly \$300 million during seven years. Our programs of cost sharing and savings have made it possible to charge our patients less than hospitals of similar size and kind outside of our system.

Our independent auditors identified \$10 million in net savings during the year 1980, resulting from shared programs. And as a result of the net savings of those shared programs, our cost to our patients ran

12½% below other hospitals of like size and kind in our region, and 23% below the national average.

The second expectation, as mentioned, relates to the system's ability to attract and retain quality management. Our record in this regard has also been positive. We just lost our first Vice President; our team has been together for seven years. It was hard to lose Diane Moeller who has just taken a position with a Catholic health care association. While it's hard to see her go, we applaud her purpose there, which will be to attempt to strengthen the Catholic systems and help them to grow, and help their systems to develop.

We've had no difficulty at all in attracting quality administrators and we've had no difficulty at all attracting highly qualified management specialists.

The vast majority of our promotions have been within and this has provided career paths for our administrators. On occasion, of course, we purposely go outside of our system in order to inject other experiences and disciplines which is necessary to maintain our vitality. Almost all of the administrators in our system have moved up the career ladder in our system since our organization in 1975. I believe that we are meeting the expectation that systems should be able to attract and retain and promote quality administrators and professional managers in the sub specialities.

I'd like to talk to you about incentives because I think this makes a great deal of difference in attracting and maintaining professional managers. In this regard, we have taken a lesson from our proprietary competitors and other national corporations.

Our board is performance oriented; management is similarly oriented. We have learned from experience that hospital administrators can be given incentives, and if those incentives are directed correctly, they can make a big difference in the progress, success, and the accomplishments of the organization.

Our key managers are on two incentive bonus systems. One is an annual system where specific goals -- this year, 30 -- are defined at the beginning of the year, they're put on paper, they're presented for approval, and then at the end of the year we return a report on our progress. If the progress has been favorable, and I won't go into the formula, there is the potential for an administrator in our system and for our Vice Presidents to earn a bonus of between 10 and 20%. That catches the attention of the administrator and our central management, and focuses their attention on the goals of the corporation which is very important. In addition to that, our board has initiated long term incentive programs that are four years in nature, that roll over on a two year basis. Not only are we concerned about the immediate year and its goals, but we also feather those in to a long range plan for the corporation.

So, theoretically we know where we're going because of our long range planning and we have a system of getting there by providing the proper incentive back to our managers to get us there. Those bonuses are significant. Our administrators and our central staff can make fine, substantial bonuses every two years on these rolling four year plans if we're reaching our long term goals.

As one of our most conservative board members said when they initiated this program, "the best thing that could happen to Intermountain Health Care would be for us to pay every cent of those potential bonuses to the maximum, because if that happens, then we would have met our difficult

four year long term objectives."

Now, on the subject of quality, I could share with you many examples from our Professional Standards Committee about potential problems with quality, particularly in our small rural hospitals -- and we have many of them -- that were identified quickly and resolved by quiet, effective effort.

I should tell you that all of our hospitals, large and small, that can be accredited, are accredited. For a group like this, that may seem very, very minimal given the nature of your hospitals, your professionalism and your quality and sophistication. But I can tell you -- and perhaps there are some here who have dealt with the problems of a 15-bed hospital in a rural town with one doctor - it's not easy to get one accredited. But they are accredited.

We have as tough, or tougher, an internal quality review organization as the Joint Commission brings to us, and of course that's a great help and satisfying to us, when we know that we're working hard on quality.

I could give you many anecdotes, and I have several here, but I'm out of time on this set. Perhaps it is best summarized by one that I will share with you.

It happened in Samaritan Health Service, but it's transferrable to any not-for-profit system with rural hospitals. It was 10 years ago that Steve Morris asked me to join a group of hospital department heads assigned to a small rural hospital in northern Arizona to determine whether that hospital should be encouraged to join Samaritan Health Service based in Phoenix.

The specialists looked through the hospital, and we had a meeting

on the way home. I asked each of them how they felt about this hospital and whether we should or shouldn't anticipate having them join our system, and whether we could or couldn't help them. The most subdued person was the chief laboratory technologist, a very capable woman. Normally vivacious and outgoing, she sat in the back seat being rather quiet. Finally, I asked her what was bothering her and she said it was the lab. I said, "tell me about it". She said it was the lab equipment. I said, "which piece?" She said the blood analyzer. I said, "what's the problem?" She said, "I looked at it and it's not calibrated correctly".

I said, "Well, you know, that even happens at some of our hospitals, I'm sure". She said, "I know -- but it's 20 years old, and I looked at the original instructions and they didn't calibrate it correctly in the first place".

I became an early convert to the fact that larger hospitals can significantly help smaller hospitals when it comes to quality and it's that kind of motivation that has encouraged us to develop quality systems within our own organization.

Finally the expectation regarding the system's ability to gather political strength. The 300-plus members of our local hospital boards of trustees represent the social, business, church and political leadership of the major communities in our state. There is, as attested by the governor of our state, no potentially stronger political force in the state than the combined boards of the Intermountain Health Care hospitals.

Example: Two key health positions in our state legislature are the positions of chairman of the health committees in the Senate and in the House.

In the Senate, the committee is chaired by the Chairman of the Board of Intermountain Health Care. In the House, it is chaired by an associate administrator in one of our IHC hospitals. We don't apologize for that! In fact, we are now encouraging as many of our administrators, assistants, department heads, employees, board members, and friends to run for the state legislatures in the states we serve. The reason ought to be apparent. If health policy development and control in the future are going to shift in part to the state legislatures, we want to have input in that process. I think it is our right and our responsibility and I would encourage you to do likewise.

How about the future? There will be continued systems growth. The regional systems, the not-for-profit systems like Intermountain Health Care, are continuing to grow through mergers, acquisitions and management contracts and leases. They are beginning to extend their services such as insurance, data processing, management engineering and quality assurance to other hospitals on contractual bases.

We now have 100 hospitals in our network purchasing some of our shared services. If Don Wegmiller were here from Health Central in Minneapolis, he'd tell you that they are providing services to 300 hospitals in the upper midwest and midwest.

The systems are diversifying and restructuring; most of them are forming holding companies with subsidiary hospital companies and subsidiary for-profit companies designed to generate new revenues to help the hospital with capital development.

IHC incorporated an insurance, a professional services company and an affiliate services company last month in an attempt to begin to

generate revenues to help our hospitals.

There will be stronger national alliances through organizations such as Associated Hospital Systems, sharing service on a national basis. And then I believe there will begin to be the coming together of the regional not-for-profit systems into organizations of national profile.

The rationale will go like this: if it makes sense for two hospitals in a town to merge, and there are advantages, and then it makes sense for those two hospitals to attract other hospitals in the state to form a system, and there are advantages in the region, doesn't it make sense for not-for-profit regional hospital systems to join together to form national organizations?

In the beginning, it will be through loose affiliations, later through joint ventures and finally, I'm convinced, through consolidations. I think that's what we'll see in the future.

I would like to make a proposal to you, and this is a little presumptuous. The proof of all this, of course, like anything else, will be time. May I invite myself back five years from now? I would like to return to report - to see how many of these predictions have come true.

I look forward to the opportunity. Thank you very much.



association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"STATE RATE REVIEW AND HEALTH PLANNING: REGULATORY ALTERNATIVES TO COMPETITION"

Presentation by BRUCE C. VLADECK, PhD

Thank you very much for the introduction, Mitch. I must thank everyone connected with the planning of this conference, both for their hospitality and their kind consideration. In particular, I want to thank them for the scheduling of the prior presentations.

I had substantial trepidation, I will confess, in preparing a talk to an audience composed primarily of hospital people on the virtues of state-operated rate regulation and other regulatory programs.

I had what I thought was a pretty good case to make, but still felt substantial anxiety. Then John Iglehart made the first of my points last night, and Dr. Buchanan made many of them in broad brush this morning. I feel substantially more at home already, and I'm going to try to fill in some of the specifics relative to the general theme.

I want to do so by making four points. Let me run through them, and then I'll go back in more detail. The first is that the evidence continues to accumulate that, at least in the gross sense of making an impact on the costs of hospital care without any obvious evidence of all the most baleful consequences that have been predicted, state hospital rate regulation works.

The second point is that much of our discussion of these issues, particularly of the competition versus regulation dichotomy, has ignored the extent to which regulatory systems differ. I think we now know enough to say that certain kinds of regulation aren't so hot; certain other kinds

seem to be substantially more promising. I think it's important to talk about some of the things that distinguish one type of regulatory system from another.

The third point I want to make -- although it's been made to a considerable extent before in this conference already -- is that the question about any system that seeks to address a particular problem such as affordable health care for everyone is always: compared to what? What are its advantages and disadvantages, compared to possible alternatives? I think we have to look at the environment a little bit in order to evaluate where we are or should be going with state-operated regulatory systems.

The fourth point is not so much a point as a topic. I want to conclude by considering some of the special concerns of teaching institutions, and of our major academic medical centers, relative to the general issue of health care costs, health care financing, and the future of regulatory or competitive approaches to these problems.

To get to the first issue, the question of the efficacy of rate setting in reducing the rate of growth of hospital costs, Figure 1 is a chart you all have seen before. It's recently been updated, but basically the dotted line is the annual rate of increase in expense per adjusted admission in 45 states without consistent rate regulation programs, as opposed to six states which are now defined as having mandatory rate review systems. As you can see, the lines cross at about 1975. By and large, the states which have adopted rate setting systems have done so in part because they were states with particularly high costs--and since the initiation of those systems, the rate of cost increase has been substantially less. In general, cost increases in the regulated states run two to four percent per

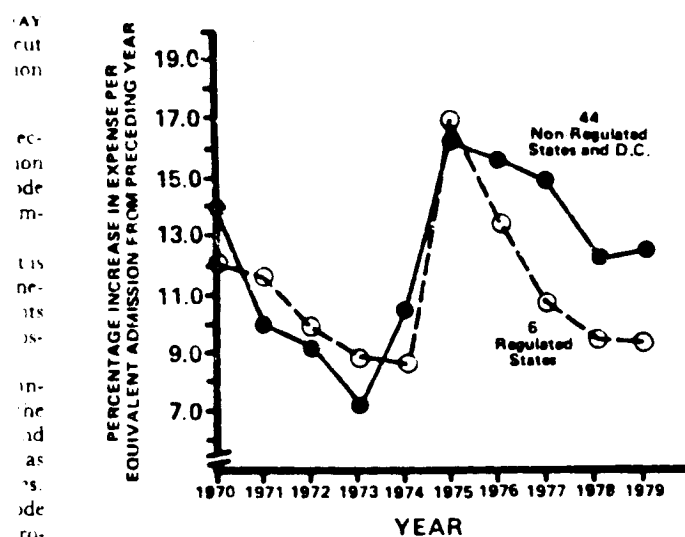


Figure 1. Rates of Increase in Expense per Equivalent Hospital Admission in States with and without Cost Regulation, 1970-1979.

year below the non-regulated states.

Figure 2 shows that, while there is substantial variation from one state to the next, the pattern is consistent across the six states that have had the most effective regulatory regimes. The literature keeps growing. The view that the 2 to 4 percent differential in rate-setting versus non-rate setting environment holds up is confirmed by economists of increasingly conservative political stripe, as well as by the Congressional Budget Office and the General Accounting Office, and other organizations without very obvious ideological axes to grind. If state regulation of hospital rates were part of a controlled clinical trial, it would be necessary to interrupt that trial by now.

The real question is how: why should it work? There are essentially two general hypotheses. The first is that of the General Accounting Office, which basically says that hospitals have traditionally been entirely autonomous and unconstrained in setting their prices, expenditure patterns, and budgets, and that in the early stages of regulation the simple requirement that hospitals generate formal budgets and defend them in a public forum is likely to lead to a degree of reexamination, a degree of need to justify certain things, that is probably worth two or three percent in the growth rate in the first couple of years.

The more generic issue, though, and it is critical--it's critical to which systems work and which don't and why--is an issue that we increasingly talk about in terms of the American economy as a whole, but don't talk about nearly enough in terms of the hospital sector. That's the issue of productivity.

You're all familiar with the kind of table represented by Figure 3, which shows the annual rate of increase in inpatient hospital expenses and

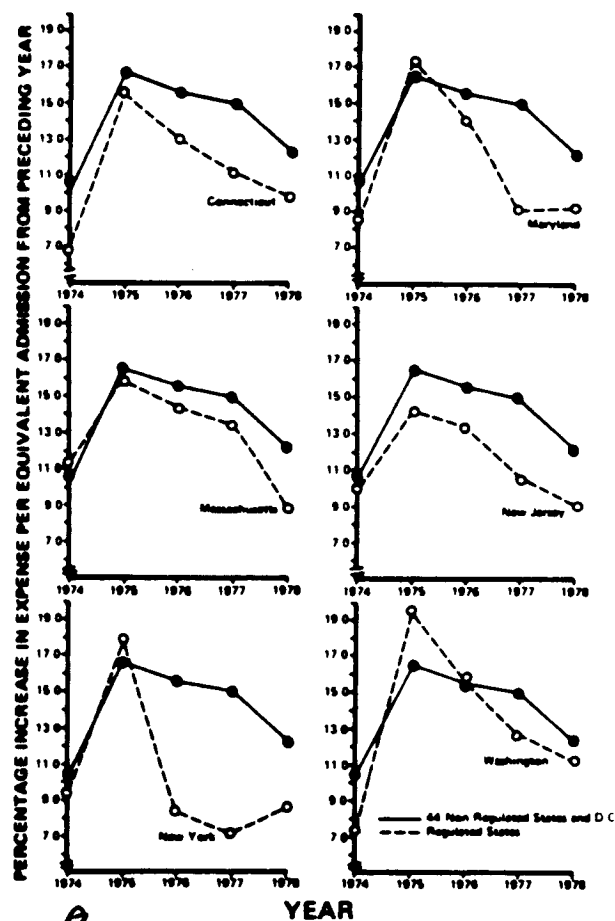


Figure 2 Annual Percentage Increases in Expense per Equivalent Admission (EPEA) for Each Rate-Setting State Compared with Increases in EPEA for Non-Rate-Setting States, 1974-1978.

Figure 3

**ANNUAL PERCENTAGE INCREASES IN INPATIENT HOSPITAL
EXPENSES, HOSPITAL INPUT PRICES, ADMISSIONS, AND SERVICE
INTENSITY, 1970-1981^a**

Calendar Year	Inpatient Expenses	Input Prices	Admissions	Net Intensity^b
1970	17.2	6.5	6.3	3.5
1971	10.6	5.2	0.4	4.7
1972	11.6	5.0	2.6	3.6
1973	11.3	5.7	3.5	1.7
1974	15.5	9.1	3.7	2.1
1975	16.8	11.0	0.3	4.9
1976	18.7	8.7	3.4	5.6
1977	15.2	8.0	2.5	4.1
1978	12.3	8.7	0.4	2.9
1979	13.3	9.4	2.7	0.8
1980	16.8	12.7	2.9	0.7
1981 ^a	18.5	13.4	0.9	3.6
<hr/>				
1970-1981^a (Average annual increase)	14.8	8.6	2.5	3.2

SOURCES: Inpatient expenses, input prices, and admissions based on data from the American Hospital Association. Net intensity calculated as a residual.

- a. Data for 1981 are annual rates based on the first seven months only.
- b. A residual category of expenditures not accounted for by the input prices or admissions factors. Along with additional resources applied to patients' care, it may include productivity changes, changing patterns in use, errors in the measurement of input prices, and time lags between input price increases and expenditure increases.

breaks it down into three components.

The first is input prices, and hospitals do suffer from inflation in the general economy. The second is admissions volume. Obviously, part of the reason for the increased expenditure is that, as the population ages, we treat more patients in hospitals.

The third column shows what is called "net intensity." Net intensity encompasses many things, including changes in therapeutic patterns, increased quality of services, and the availability of new kinds of services that never before existed. But in some sense, it is also a measure of our productivity in the production of the basic units of hospital services; that is, in the number of inpatient cases we produce, of inpatient units of care we produce, per dollar with which we product them.

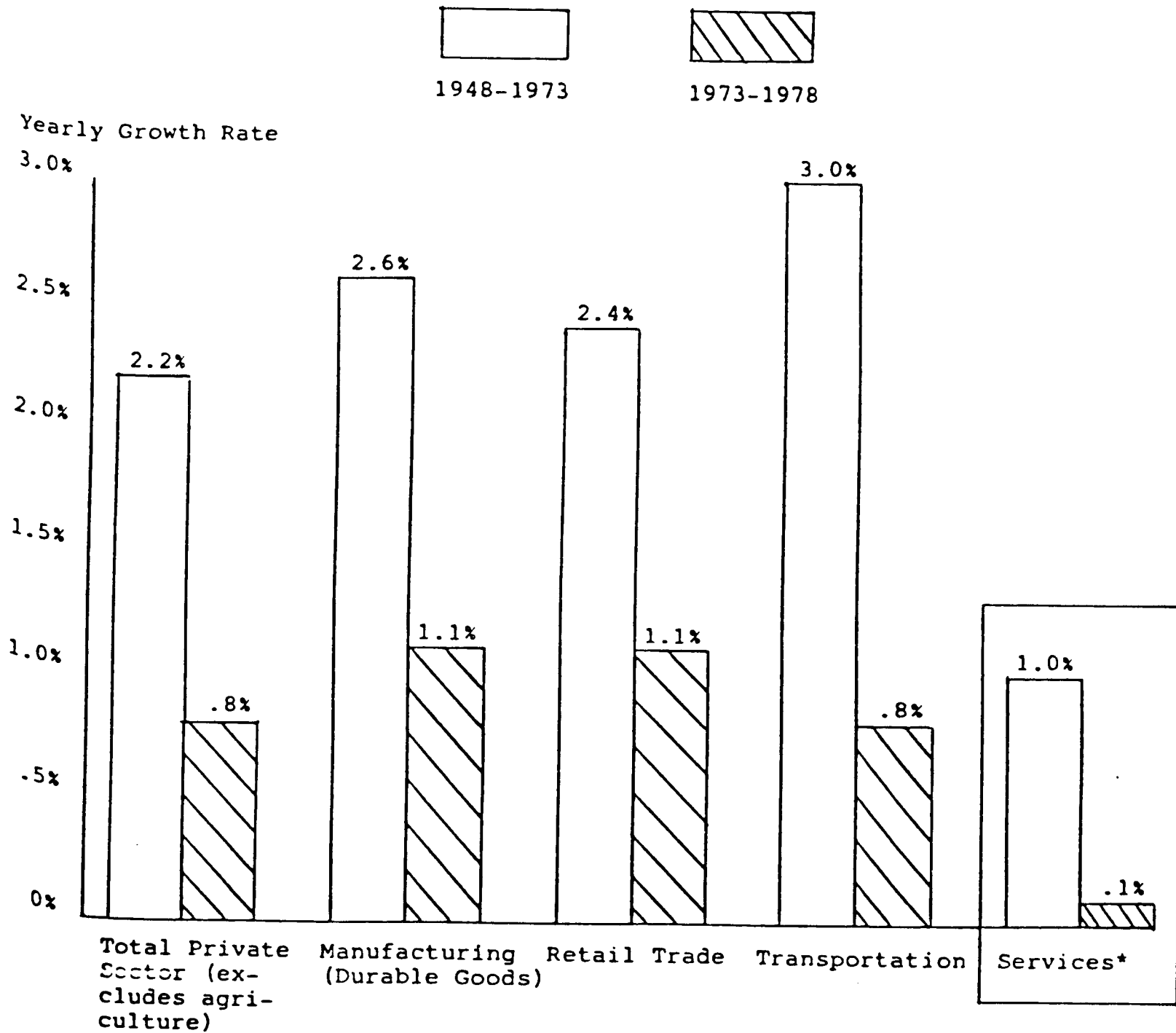
In most industries, over time, even with substantial qualitative improvement, this number tends to be a negative number. That is to say, you can increase the quality of what you provide, per unit of output, even in the face of inflation, through increases in productivity. There is no question that hospitals provide different services, of higher quality, than they did in the past; there is also no question, however, that at a minimum, there are very serious problems of productivity in the hospital industry.

Some part of that problem is reflected in Figure 4, which shows that, in general, productivity is a problem in all service industries. They tend to be relatively labor intensive, or they tend not to be quick to adopt new technologies that save labor, rather than increasing labor. There is a problem of productivity growth in service industries, and particularly in the hospital industry.

There is substantial excess capacity in the hospital industry, not

FIGURE 4

CHANGES IN WORK FORCE PRODUCTIVITY BY INDUSTRY,
1948-1973 and 1973-1978



* Includes nonprofit institutions

only in terms of the number of beds, but in terms of the use of very expensive equipment and technologies at less than their economically optimal levels. I was astounded by the statement a little while ago that only 40 percent of open-heart surgery is done in teaching hospitals. I sort of knew that. But there are still lots of hospitals throughout this country doing 50 or 75 or 80 open heart procedures a year. There are very serious qualitative problems with that, but there are also very basic productivity problems.

There has been a consistent trend, throughout the last 20 years, of increasing full-time equivalent employees per bed in hospitals. Some of that represents the availability of new services, but some of that raises questions about the way we use labor in the hospital sector. Finally, there is the issue of what economists, with a term I love, like to call "x-inefficiency;" in the absence of certain kinds of constraints, organizations develop a degree of slack, above that which a perfectly competitive theoretical market would permit. I think everyone would agree that--except at their hospital--there is a substantial degree of slack in the hospital sector.

Every so often, I'm given to facetiously suggest that perhaps the major problem we've had in this area is that hospitals have not begun to feel a threat of competition from the Japanese. I'm not sure the productivity malaise in the hospital industry is radically different from that in a number of other very large industries in our economy, and I certainly don't think one can make a convincing case that the productivity situation in the hospital industry is better than it is in steel or autos or other places where we are in serious trouble.

It is possible, through an appropriate set of regulatory incentives

and regulatory directives, it seems to me, to get at some of these productivity problems, and I want to move on to talking about how you do that.

Let me move to the second point, then, of the difference in regulatory systems, but begin with a sort of digression. If you talk about differences in state regulation from one place to another, one of the things that those of us who are somewhat less of a minority than we used to be in terms of state rate-setting have always had to deal with is what might be described as "the problem of New York."

New York State has had far and away the most aggressive regulatory system, claims far and away the largest savings from state rate regulation, but also has the largest hospital operating deficits, and certainly the loudest cries from its hospital industry about the perils of a regulatory regime. As someone who has been involved in sort of a peripheral way with the New York State system since the late seventies, there are a few things I want to say about it—because it has been used as the prototypical or paradigmatic case of state rate regulation.

There are a number of very special things about the circumstances in New York which—as all of you continue to hear about New York as proof that you shouldn't do these sorts of things—I think you ought to keep in mind.

There are, just by coincidence, four points here that I want to make, the first of which is that the experience of the New York hospital industry and the experience of New York rate setting activities since 1975 were very specifically and self-consciously a reaction to an extreme form of fiscal crisis of the kind of which you are all aware, but of a kind that was really, at least to that point, unprecedented in the history of American municipalities, at least since the period of the Depression. People in 1975, you might recall, were talking with some seriousness about the col-

lapse, if not of the entire financial structure of the United States, then certainly of the tax-exempt structure of the United States-- 30 percent of whose paper was New York paper for which there were not adequate funds to repay principal.

The State and City governments have taken a number of steps to address that crisis, of which their response to hospital care has only been one. I think if you look across the range of public services or publicly- supported activities in the state of New York in the last several years, the hospitals--while not faring particularly well--have fared at least as well as the subways or the city university or the state university in a period of extreme budgetary stringencies. I think there may be a lesson for the future in all of that, in terms of the competition that has been felt, and quite consciously in the state government, between the costs of hospital care, the support of higher education, the support of elementary education, and the support of public transportation.

The second thing that is not widely recognized, and it really gets to my central point today, is that from 1975 until last year, New York State, which had had by most measures the most generous Medicaid program in terms of eligibility--as well as in reimbursements to providers--essentially froze eligibility levels, notwithstanding inflation. Between 1975 and 1980, New York State lost more Medicaid eligibles than any other state. The problem of hospital deficits in New York State, and particularly in New York City is, to a considerable degree, a problem not of Medicaid or Blue Cross or the other regulated payers. It is a problem of non-payers and their increasing number, in an environment in which the cost payers have been unwilling, it is true, to subsidize services to the indigent poor.

And this is also in a city where, on a per capita basis, roughly twice

as large a proportion of the population has traditionally received ambulatory care from hospital-based outpatient departments than is the national pattern. Two-thirds of the losses in New York City hospitals have been in their outpatient services, with the great bulk of those losses attributable not to Medicaid patients, or Medicare patients, or any paying patients, but to non-paying patients, in a particular kind of vicious cycle.

The third thing I will suggest about the New York experience is that while as a result of both the recognition of a crisis in the financial system and a crisis in the health care sector, there has been a substantial reduction in the number of hospital beds and hospitals in the city of New York, the fall in the number of hospital beds has been smaller, proportionately than the reduction in the population over the last 15 years. The City of New York in particular, and the state as a whole, have been undergoing a very dramatic kind of demographic change, and that obviously gets to the general issue of the financing and size of the health care system.

The last point, though, I want to make about New York is that governments, believe it or not, like everyone else, appear to be capable of some degree of learning. There is now, for the first time in 10 years, what appears to be a general consensus among all the major parties, including state government and the hospital industry, on the extent to which the hospital financing system in New York State needs to be reformed. There is a new application in to the federal government for Medicare participation in a new system which arose out of a relatively participatory process, at least on the part of the hospital industry and the state government.

There is also a bill pending in the state legislature, with the support of the hospital industry and other provider groups, as well as state government, to go to a new system. I am pleased to say—moving on to the

second part of the issue, of the difference in state regimes--that the model for the system that's being discussed in New York is the systems that have been in place in Maryland and in New Jersey for the last number of years. There are many important differences between the New Jersey and Maryland systems, but they have two critical features in common.

The first is true prospectivity. If costs are below rates, the surplus redounds to the hospital, as opposed to the Catch-22 in New York, or other places where you have a ceiling on costs, but no floor on revenues if costs are below rates. In New Jersey and Maryland, the difference between a hospital's costs and its revenues is all income (or deficit) to the hospital.

The second critical feature of the Maryland and New Jersey systems is, of course, that all payers participate in a uniform system of payment, and their payments are adjusted to include the costs of services to the medically indigent, those who have no insurance but can't afford to pay for care.

The general result in those two states has been continued levels of cost inflation substantially below national averages along with substantial improvement in the operating results of some, though not all, hospitals.

I think it's significant to point out that there are important distributional and allocative effects from these systems. The winners, as it were, are hospitals which have traditionally served a large number of non-paying patients. The losers are those which have gotten fat and comfortable on a large proportion of charge-paying patients and were unrestricted in terms of the revenue they could generate from them. There is no question that the sort of systems in place in Maryland and New Jersey provide a self conscious subsidy—a tax, as it were, on those who pay for hospital

care—to the providers of service to the uninsured. That is a subsidy which I am very pleased to defend.

Having said that, I want to move on to the question of alternatives. I think once upon a time when people talked about rate setting systems, certainly in their earlier guises, and the basis of comparison was a world in which Medicare paid reasonable costs, Medicaid paid reasonable costs, Blue Cross paid retrospective costs, and everyone else paid charges--were I in the shoes of a hospital administrator, certainly in the short run you'd have to be an idiot to look forward to increased regulation of your revenues.

We're not talking about that sort of system any longer. Whatever else may happen over the next number of years, government expenditures in real dollars for the health care sector—either at the federal or the state level—are just not going to increase, whether its Reagan or someone else who is making budgetary decisions. I think there is a broad consensus in America that federal and state governments are paying more than they can now afford, let alone being able to continue to afford to pay more.

We do have a proposal from the American Hospital Association, of all organizations, for prospective reimbursement under Medicare. I suspect that proposal will not survive in its current form, but I think it does indicate a recognition on the part of the hospital industry that a predictable, fair prospective reimbursement system is substantially better than what may be the alternatives, which are a series of relatively arbitrary and retrospective cuts in what Medicare is prepared to pay.

I have a couple more charts that come out of some economic forecasting models, relative to projected increases in state and local, and then federal government expenditures—and this is again, from the macro-

economic view over the next decade. (Figures 5 and 6) As you can see, even if the economy improves, with the tax structures we now have in place, the revenues are not going to be there, either at the state and local level, or at the federal level, to continue the growth rates of overall government spending, and of course Medicare and Medicaid have grown substantially faster than overall government spending.

Let me make my last point with the last chart. Figure 7 shows the proportions of total revenues in 1970 from several sources received by various actors in the health care system. What it shows is that about 56 percent of the revenues of community hospitals are public in origin, in one form or another, as are about 60 percent of the revenues of medical schools. If you take the academic medical center as a complex, I suspect it probably falls pretty clearly somewhere in between, on average, the medical school and the hospital in terms of its reliance on public funds. There is obviously substantial variation from one place to another, depending particularly on whether you have a state supported institution or a private institution. But in general, we have 100 some-odd academic medical centers in the United States which have become, or many of which have always been, reliant on public funds for a large proportion of their total revenues.

I don't think I'm telling any of you anything you don't know when I say that; I also don't think I'm telling any of you anything you don't know when I say that in addition, academic medical centers, particularly in urban areas, have been major providers of service to the poor, to those who have no other place to turn for care, and at least in the short run, there are more such people than there used to be. Between October, 1981 and October, 1982, approximately a million and a quarter people, of whom

FIGURE 5

PROJECTED GROWTH RATES OF STATE AND LOCAL
GOVERNMENTAL EXPENDITURES, AND EXPENDITURES
FOR HEALTH, ADJUSTED FOR INFLATION
1970-1990

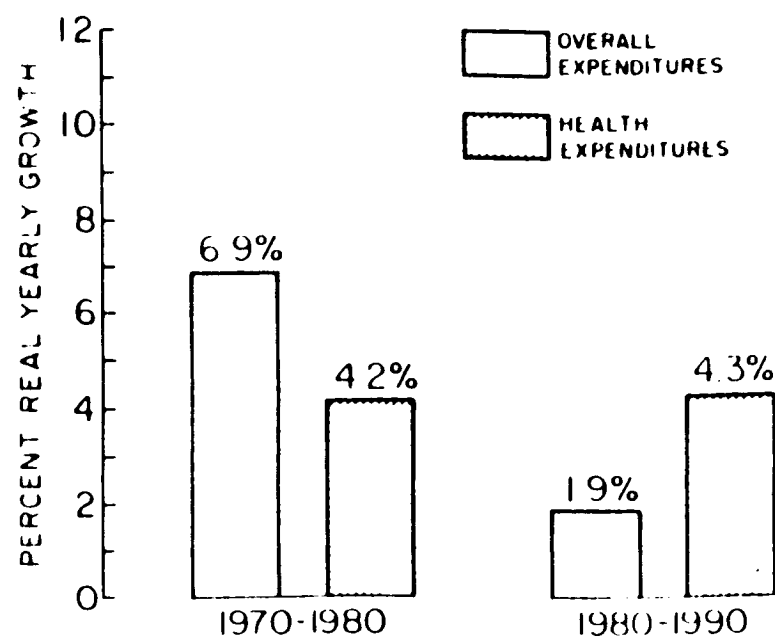


FIGURE 6

PROJECTED GROWTH RATES OF FEDERAL
GOVERNMENTAL EXPENDITURES, AND EXPENDITURES
FOR HEALTH, ADJUSTED FOR INFLATION
1970-1990

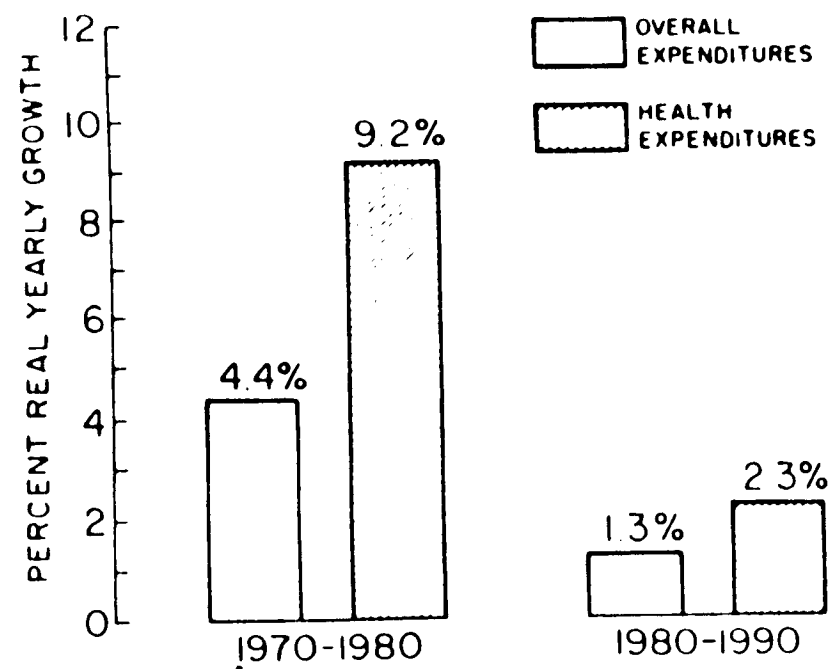
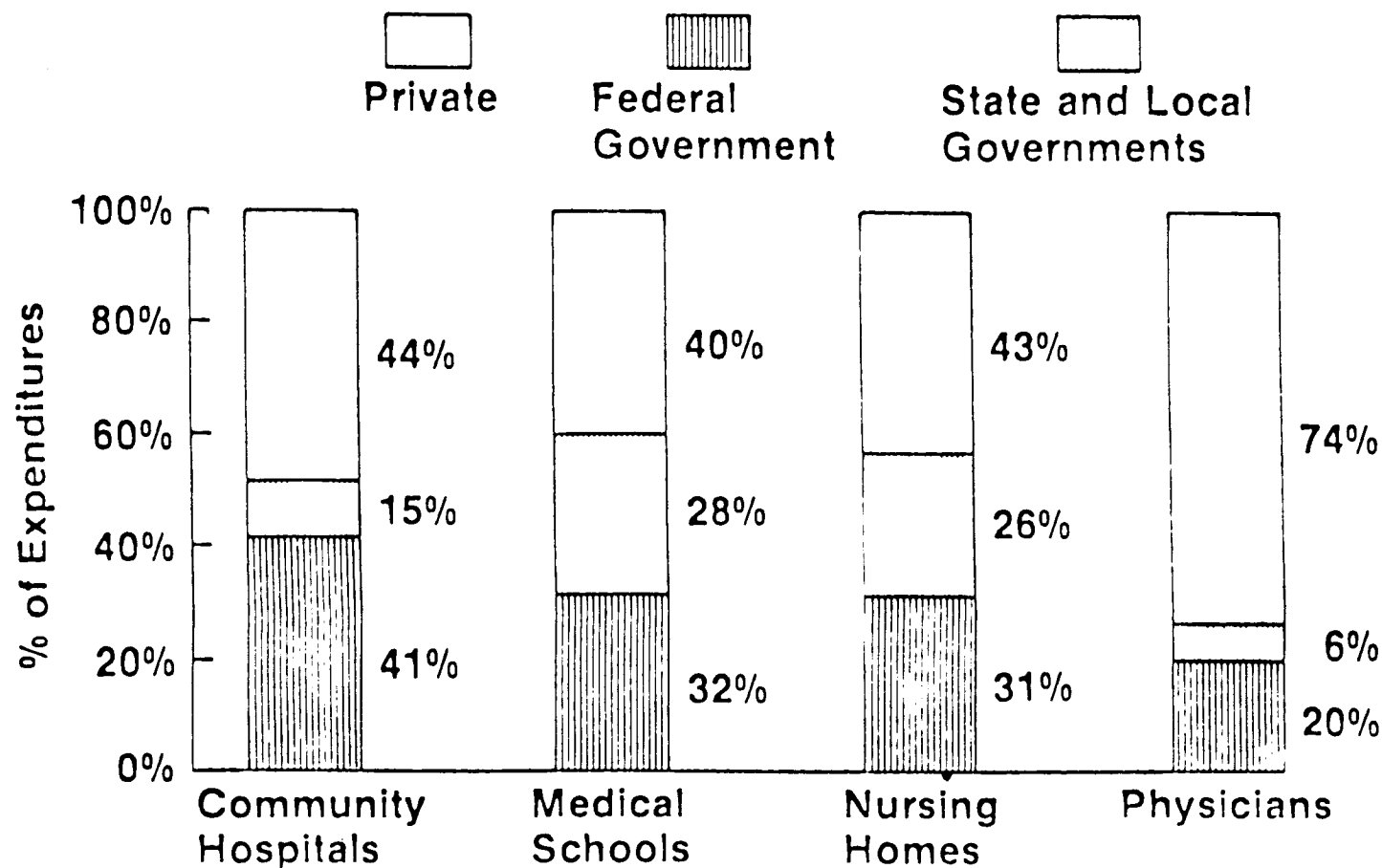


FIGURE 7

SOURCES OF SUPPORT COMMUNITY HOSPITALS, MEDICAL SCHOOLS, NURSING HOMES, PHYSICIANS 1979



825,000 are children, are going to lose Medicaid eligibility in the United States. That ignores the impact of unemployment on the availability of private health insurance.

There is a real squeeze, and I think the squeeze is unavoidable. There are two directions in which one can go. The first direction is to attempt to live with stringency, with the reductions in public support, by an increasingly conscious strategy of robbing Peter to pay Paul, in the sense of extracting adequate surpluses from private sources of funds to subsidize publicly-subsidized or entirely non-subsidized patients. In a lot of places, that is simply no longer practical; over time, as purchasers for health insurance become more conscious of their costs, it will become less practical.

I don't see that alternative as one likely to sustain itself over a long period of time.

The second alternative, it seems to me, is to talk about systems of financing health care which explicitly acknowledge that for the last 100 years we have built what is really the world's finest system of health care on a whole series and network of cross subsidies; cross subsidies of one department by another, of one procedure by another, of one patient by another. The only way to make rational sense out of a system of cross-subsidies, as we're beginning to learn in the area of telecommunications, as we've known for some time, I suspect, with airlines, is to establish the appropriate kind of regulatory system. I'm not saying that that's necessarily the system currently in place, but it is a regulatory system.

I don't want to take the too-easy shot of saying that all those Braniff planes flying back to Dallas/Ft. Worth have something to do with the elimination of rate regulation in the airline industry, except that it

pretty clearly does have something to do with the elimination of rate regulation in the airline industry.

And I'm not sure the public is better off as a result.

I think we need to move, and I feel increasingly less of a minority, into a system of prospective financing in which everyone plays. Our choices are either substantial cuts in Medicare and Medicaid, on one hand, or a uniform system with everyone playing at the state level, on the other hand. I think there are strong arguments to be made for the state system in which everyone participates.

In that regard, let me make one further point. There is a tendency for many of us, including myself, who are concerned with large institutions and who grew up in the sixties and seventies, to assume that the action is in Washington, that the things that are most going to affect peoples' lives take place in Washington. One result, if nothing else, of the new era in American government that began in January of 1981 is that is going to be increasingly less the case.

Don't underestimate the potential contribution that all of you can make at the state level if you realize the significance of that arena to your future. Washington is going to set the basic ground rules, but the real decisions about where the money goes are increasingly going to be made in the state capitals. The drug companies have already figured this out; they are all increasing the staffs of their bureaus in state capitals.

Many of you, particularly those of you from state schools, already have a series of relationships with state government of one kind or another, and you are probably aware in many ways how desperately eager state bureaucrats often are to be given good information or good advice.

I mean that not just as a kind of rhetoric—you know, "keep the cards

and letters coming in"—but as an observation of what really occurs.

On that note, on that sort of call-to-arms for all of you, I will leave you—I do have in my other pocket, for those of you who want to participate in the process of establishing these systems, a very nice set of DRGs that I want to sell, but that's another speech.

Thank you very much.

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association of american medical colleges

1982 COTH SPRING MEETING
Boston, Massachusetts

"A SUMMARY REVIEW AND SOME THOUGHTS FROM A DEVIL'S ADVOCATE"

Presentation by ROBERT A. ZELTEN, PhD

One thing nice about being an academic on a program like this, and one of the reasons I accept speaking engagements is that there are two things accepted of an academic. One is that you don't have to be well-groomed. There can be a group like this that looks very sophisticated, very business-like, very polished and it would be absolutely acceptable for me to walk around in jeans and short sleeves, and everybody would say, "fine." The second thing that is even a bigger benefit is that I don't have to be "relevant". Bob Biblo almost blew my cover a little while ago, indicating that he thought I had produced a couple of things that were helpful in the HMO field; but I'll try not to lose the reputation of not being relevant entirely by saying some things that are absolutely extraneous and not to the point in the next 40 minutes or so.

It's difficult to be a devil's advocate. With the exception of a handful of the presentations that I listened to, I thought much of the information that I heard was descriptive. Recognizing the caliber of audience that is in this room today, perhaps the speakers didn't push our minds into the corners we should have been pushed to consider carefully some of the major issues that are and will be confronting us during the next several years, and how we might cope with them.

The side-bar conversations that I heard -- or overheard -- without specifically asking the question were along the lines of, "Gee, I didn't really think what that individual was describing was relevant to my own situation. They must be talking about someplace else."

Well, sometimes that was true. I think some of what was discussed as not relevant to your situation. But other times perhaps it was, and you just didn't recognize it.

What I'm going to do -- and I'm not sure yet what I'm going to do, as I'm thinking about it as I talk to you right now -- is not spend a great deal of time summarizing what I've heard. However, I want to summarize a little bit, to make sure that you understand what I heard, since it is the basis for some of my later comments.

But, I'm not going to be so much a devil's advocate as try to present a different way of looking at some of the things that were said today, and maybe give you a different reason for either embracing the concept or discarding it, as the case may be.

So -- let me first of all give you a little bit of an overview of what I thought this program was structured to do in the first place by looking basically at the agenda.

I thought it was divided into two major parts. The first one was kind of an environmental assessment, if you will. John Iglehart spoke about the Washington political and budgetary scene. We followed Iglehart's opening remarks yesterday morning with two presentations -- one by Dr. Buchanan and one by Bruce Vladeck, which contrasted the regulatory approach and the competition approach. Interestingly, I thought they arrived at the same conclusion, by and large.

After we set that basic foundation, we moved into a discussion of strategies for coping with what was stated in that foundation. What are the actions that we can take or not take to make sure that our institution is protected in the long run? First, we heard Scott Parker and Allen Hicks discuss the multi-institutional systems approach. Then we heard a tentative assessment of governance issues and how well teaching institutions are going to be poised to take advantage of what happens in the future. We heard that from Myles Lash and Fred Munson yesterday afternoon. These were the first two of three Marx Brothers performances that came along -- Myles even looked a little like Groucho, I thought.

Another approach we heard was basically nonhospital-based competition, and the third Marx brother, Karl "think-about-it" Mangold, told us essentially that there are termites out there nibbling away at our foundation and if we aren't careful, our house will tumble like a stack of cards. J.D. Epstein then talked about restructuring as a possible strategy for coping with the future.

This morning we heard about marketing strategies in a more generic presentation by Jeff Goldsmith which I thought was outstanding, and we also heard Bob Biblo present a sincere explanation of relationships between teaching institutions and HMO's. I thought Bob's comments were well-reasoned as opposed to some of the presentations you might hear, either from hospitals or from HMO managers with regard to those affiliations.

So those were the coping strategies. I'm now going to zip through a summary of this material, and I'm going to do this very rapidly. It's always one of the criticisms that I've had as a professor at Wharton. I really go like a scalded dog, and the students are always telling me to slow down. However, I have a philosophy that some of you may have heard me espouse before. One of the ways you survive as a teacher is just don't let the bastards look up -- you know, just keep them writing!

So here we go. Let's talk about John Iglehart's presentation for a

moment. I think there were three or four things that John brought forward for us that were reiterated subsequently. I'll spend more time summarizing what some of the first few people said rather than the last ones because some of the things said were a bit redundant. The theme of the last five years that John Iglehart pointed out for us is that we're seeing a trend toward more individualism and less public authority, a real trend that is evidenced by back to basics, and a real realization that we have essentially reached the limits of public benevolence, if you will.

He also expressed a feeling on the part of the people who make policy that what we ought to be doing about resource allocation is not some arbitrary and capricious top down allocation of resources, but rather a resource allocation that starts from the bottom up. Let people tell us what they want in a market structure that operates rather freely, and when we get to the result then, at least it will reflect an allocation of resources that (never mind the result in total dollars) occurred through a process that's more satisfactory, more in keeping with the democratic and capitalistic principles that we embrace in this country.

Then he pinpointed, I think rather effectively, the consequences of the shifting in philosophy between the Carter and the Reagan administrations. He talked about the Carter administration basically being one that really believed it was government's responsibility to regulate the entire health care industry and all of its aspects. It's a point that was made I think rather forcefully by him. He then talked about the shift of the Reagan administration where there's a much narrower view of government's responsibility -- and quite frankly, a view that is socially much harsher than the views that were espoused by prior administrations.

He used as evidence this government becoming much more aggressive purchasers of health care. Just as an aside here, I think what's going to happen (a prediction) is that the actions that are going to impact on us most are going to result from things that are already in place, rather than from anything that's going to happen in the next several years. And it's not just the things that Jeff Goldsmith talked about with regard to competition and what's going on out there today. I think that largely, the public sector is going to exercise a lot more of the authority that it already has under the Medicare and Medicaid legislation.

I suspect the next thing that will happen to save costs in the Medicare program will be the expansion of 223 limits to ancillary services -- and much more of a prudent buyer concept. The law says that the government will pay the "reasonably and allowable" costs of care -- and everything that's been done in the past has looked at allowability. Nothing is focused on reasonableness. The whole area of identifying the increases in intensity that have come about that was talked about by Bruce Vladeck is I think a series of very critical points. Regulators are going to try to wring the nonproductivity out of the system the best they can, either from arbitrary reductions in reimbursement or through some other regulatory mechanism.

Incidentally, I think that the AHA proposal for prospective reimbursement which was noted by several speakers is lousy. As a public payor, as a fiduciary of public funds, there is no way I would agree to that proposal. I don't think it's going to save me any money in the long run; I'll say a little bit more about that as we go along.

Back to Iglehart. He wanted us to recognize that health care, unfortunately, has become a pawn in a much larger game of governmental "downsizing" or "resizing" -- the word he used. A lot of the things that may happen to health care will be unfortunately fallout from other political plays that are going on to save government dollars. And, also -- and this is the point that I think was most important -- it's unfortunate that a lot of the fiscal resizing is going on through the budgetary process rather than being debated in more open forums in a policy framework. Important decisions are being made by large public interest groups with little public debate over the issues. That, of course, is catastrophic because many of the problems we have in health care are almost intractable. Any solution that is put forward if there is enough debate and discussion of it can be found to contain fatal flaws. I'm grateful that we haven't moved ahead aggressively on some of the proposals that looked very sexy initially, but after we thought about them really had some major problems.

It's like the AHA endorsing procompetition legislation at first, and then backpedaling rather rapidly. And I suspect that this organization might feel the same way about the AHA prospective payment proposal once they think about it a little more seriously.

Iglehart also commented on the weaknesses that health care has specifically in this fiscal environment. I think those points are also noteworthy. Medicare is losing its stature vis-a-vis Social Security cash benefit programs. The relentless cost increases that have been experienced in the program have people fed up. Also, increasing profiteering -- and he talked about the end stage renal dialysis program specifically -- has contributed to the lowering of health care as a priority on the Hill. He also noted the weakening position of Health and Human Services vis-a-vis OMB in the negotiation process, and the weak stewardship of health that we have been able to get from HHS and HCFA in recent years.

He concluded by saying that the regulatory and governmental view of hospitals is really not so hot. You're perceived as institutions with weak management. You have inadequate control over important facets of hospital operations -- everyone is an entrepreneur in your institution. Incidentally, we have heard your institutions torn down pretty good by two or three people, I think, in that regard; that you're really not an institution perhaps with your own mindset and your own identity, that you're really maybe a facility used by a bunch of other players trying to accomplish their own ends. I think I heard Jeff Goldsmith say that this morning. Dr. Munson said it yesterday.

And then after that very gloomy forecast, Iglehart said there's hope. Basically because health care is good and is viewed very highly by the

public, no one is going to sell health care down the river.

Then we heard Dr. Buchanan and Bruce Vladeck talk about regulation, competition and physician manpower projections as issues before us. Dr. Buchanan took an approach which led him to look at regulation, look at competition, analyze the two and see if, indeed, competition looks like a decent strategy for the country to embrace.

He summarized the events that led us to where we are today. It was largely a governmental thrust. He identified three major thrusts. First, he noted the post World War II push to upgrade facilities, to upgrade research and health care through Hill Burton funding, and programs of that nature. Second, he identified efforts to democratize the system of care; basically to make access -- equal access to care -- available to those people that are now basically wards of the public from the standpoint of reimbursement under the Title 18 and Title 19 programs. Third, he noted governmental attempts to increase the supply of medical manpower, primarily physicians.

He then moved to analyze the successes of government and the failures of government, vis-a-vis what was attempted and where we are now. I think as he stated, by and large, you have to say that government has been more successful rather than less successful in accomplishing the missions that Dr. Buchanan attributed to government.

The accomplishments basically were that governmental programs have increased access to care to certain elements of the population that had found access difficult historically. Second, that government has narrowed the inequality of treatment between various sectors of the population using the health care delivery system. Third, that the system has allowed hospitals generally to treat all of their patients better, not just Medicare and Medicaid patients, because the reimbursement has allowed funding for other activities as well.

He maintained that consumers have fared well and that institutions, by and large, have fared well, particularly under the reimbursement principles, but not so well under the other kinds of governmental regulations that have been put in place for institutions. These "other regulations" perhaps have caused problems that outweigh their contributions. He also believes there are enough physicians.

On the negative side, he said there is no incentive in the reimbursement mechanism yet to save costs or to control costs or to reduce the increases in costs. Also, we still are plagued with a maldistribution of physicians. That was the balance sheet that I heard him present to us. Dr. Buchanan said he had some real fundamental problems with the assumptions that underlie competition, and he wasn't at all sure that competition was really the route we ought to go.

He indicated that costs really were still "the bone in the throat" of the people who are responsible for paying a lot of the health care bills. He hoped that the hospital industry was not on a kamikaze mission basically with regard to government, and really wanted hospitals to ignore the groundswell of sentiment that's occurred in the last five years. Cost control really is not exclusively a pro-

Reagan kind of notion. He urged hospitals to get into the act of trying to solve some of the problems because the solutions that others will shape will not be in the best interest of our institutions.

Another aside. He indicated, as a lot of people have, that they're not at all sure that competition will work. I have a little bit of a speech here that I have to go in to. I don't really know what it means to say that competition works or doesn't work. Usually the proposers are interested in reducing costs; competition is proposed as a cost containment device.

As I'll say in a little while, if what Dr. Mangold and others are doing with outpatient surgery centers and so forth is competition, and even if Dr. Mangold can provide an ER encounter or a freestanding Emergi-Center encounter for \$40 or 40¢ versus your \$84, believe me, that's not cost containment. From a macro perspective, from a societal point of view, that's additive, that's not cost savings, and I'll give you my views on that momentarily.

The issue it seems to me is not the current level of health care expenditures, but how we get to that level. Costs are a symptom. We get to our current level of expenditures as the result of a set of incentives that drive everybody to do exactly what you or I would do if we were they. If I were a patient, and you offered me a Cadillac benefit program, you wouldn't get very far telling me not to use it. It doesn't make sense. I have an incentive to use it, on the marginal service, I'll go get it.

And if I'm a physician, if I'm a specialist, if I'm a surgeon and you pay me fee-for-service, I make a lot of money if I perform a service. If I recommend against surgery or cut back on services my income level suffers. As a result, I'm going to do the marginal procedure if I can convince myself that it's really not going to jeopardize my patient's health.

If you're a hospital administrator, what are the incentives that drive you? They're basically to make sure that you generate enough revenues to cover the budget, that the physicians on the staff are relatively happy, and that the image of the facility is what it ought to be in the community. There's not an objective anywhere that says, "be efficient."

It seems to me you can go right down the list of every incentive in the system, and you have to conclude that nobody is ripping the system off these days, everybody is behaving exactly as you would expect them to behave if you were them.

That's fortunate -- we've got a rational system. All right. If we had irrational people, then I wouldn't know how to solve the problem at all. But if they're behaving rationally, then what seems to be needed is a set of incentives that drives the micro behavior to produce a result that is macro acceptable. That's the real challenge. I am convinced that if the system was wide open from a competitive standpoint, we would be spending a lot more than nine and a half or 10%

of GNP on health care; the ability of the health care sector to generate demand for their services is almost without limit, I think. It's incredible.

I am in favor of a procompetition model that places more rational incentives before the key decision makers. While I am not convinced that we will spend less for health care under such a model, I will feel better about how we arrive at the result.

So, my response to Dr. Buchanan's remarks saying that competition really will not be successful is only true if you think competition ought to contain costs. If you think competition ought to put in place a better set of incentives for people, then I say competition can be successful. But I am not willing to say that it's going to cut or contain expenditures or that it's going to be more efficient or less costly from a health care standpoint. I think that's an important distinction to bear in mind.

Back to Dr. Buchanan's remarks. He concluded that any system that would not pay for doing more is not going to be good for teaching hospitals. Any system that begins to ration care is not going to be good for teaching hospitals. As a result, he advocated a middle position. He said, "I want a controlled approach to the problem as we move ahead." He put forth several elements of control that he wanted to see. One was a system that would promote more than just adequate equal access, and thirdly was a system that would build in incentives for self improvement. He specifically favored prospective reimbursement, patient cost-sharing and some controls to make sure public patients are cared for.

Bruce Vladeck then came along and said, "try regulation, you'll like it." He said that if we take a look at the evidence of prospective rate setting, it would reveal some real positive contributions and not the dire consequences that a lot of people predicted. And he said that there is evidence available, produced not only by the regulators themselves but by impartial people like me -- academics, that there is a rate of increase reduction in the cost per adjusted admissions of two to four percentage points below the rates of increase per adjusted admissions that are experienced in similar states without rate controls. He compared the six states that had rate review versus states that didn't, and showed a two to four percent slowing of the inflation rate in adjusted admissions.

He believes there are two reasons why this happened in rate regulation states. One is the fact that there is a public examination of budgets. There is some public scrutiny of what individual institutions say they're going to spend. Secondly, he said there's focus on that net intensity factor even though that's not the way he said it. He said, "inflation is contributed to by several factors." They are an underlying inflation rate, an increase in admissions or utilization, and a net intensity factor. The intensity factor denotes the things you do to somebody when they're occupying a bed or when they're in a hospital. Productivity levels are captured in that net intensity

factor, and that's why he thought that the rate states -- the states with rate setting of some sort of another -- basically produced positive results.

He also indicated that there are significant benefits of rate setting to many hospitals, especially those which have a large number of cost reimbursed patients. Rate setting methodologies often attempt to distribute the burden of caring for nonreimbursed and under-reimbursed patients across all hospitals instead of forcing only the hospitals that care for these patients to incur the financial penalties.

I heard a nice comment in the elevator after he spoke from somebody in New Jersey who said, "one of the interesting aspects of the DRG system after it was imposed in New Jersey was a real awareness on the part of physicians of what they were doing with the institution." They really became physicians, who, to some extent, acted more in the best interests of the institution because they were getting information and feedback on how they were treating certain DRG categories as opposed to their counterparts, both within that institution and in other institutions. The hospital found changes taking place with regard to lengths of stay and the mix of services that were provided to patients when they were in the hospital.

Dr. Vladeck also wanted to make sure that we recognize the vast differences in prospective rate setting systems. "Don't think everybody's like New York" is essentially what he said. He also discussed two features of rate setting that he thought were very important. He thought Maryland and New Jersey had them. Basically, the rate reimbursement system should involve true prospectivity. Hospitals should not have to fear being ratcheted down every year. Second, all payors have to participate uniformly in taking care of uninsured patients. That presents a real problem for Blue Cross in many of the northeastern states where they enjoy significant discounts from charges. As the discount from charges disappears, Blue Cross must face stiffer competition from commercial health insurance and from self-insurance.

Finally, he warned us that health care regulation was switching more to the state level. The locus of control was leaving Washington and that if you think the federal government is hard up for money, you ought to see the state situation. There is going to be a lot less purchasing power available, so look out.

Subsequent speakers focused on coping strategies. We listened to Scott Parker and Allen Hicks talk about multi-institutional systems. We heard that about one-third of all the beds are in a multi-institutional system of some sort, and Scott Parker put forth four conceptual reasons why people propose multi-institutional systems. He said they respond more effectively and more efficiently because of shared services both on the medical side and the management side.

Secondly, he said they have the ability to attract management specialists that can see career paths in hospital management that are meaningful. Thirdly, they can improve quality through reduced

duplication, peer review, feedback and so forth among institutions in the system. Finally, they can build a political profile with stature.

He noted that a lot of people have asked for evidence that all of these points have positive substance to them. He offered the results of his own multisystem. With regard to cost, he indicated that charges were less than comparable hospitals in comparable settings by 12%, and 23% below the national average.

As regards management stability, they did not lose a Vice President for seven years. The full management team was with him for seven years, and they have no problem attracting management. Most promotions occur from within. They put in place very significant entrepreneurial motivations through an incentive system they have.

With regard to quality, they calibrate blood analyzers like crazy, improve the position of the smaller hospital in the system, share some services, and allow smaller rural hospitals to continue to exist.

On the fourth point, Mr. Parker noted that the combined boards of the Intermountain Health Care, Inc. really have some immense clout, contributed to greatly by the fact that they encourage employees to run for public office at the state level. He noted that they had a couple of people in the state legislature that were part of their system.

He predicted that they would grow and presented what was a rosy picture for multi-institutional systems; even though the narrative is always that we will see sharing of clinical services, I certainly cannot identify many cases where there really has been a sharing of clinical services. The management services perhaps are shared, but there still remains a lot of clinical duplication in multi-institutional systems as far as I can see, and it seems to me that's where some real cost savings can take place. I am very sensitive to the problems of bringing such savings to fruition, however.

A curious fact that I think is useful for you to bear in mind is that the nonprofit sector is hurting the for-profit sector in one very peculiar sort of way. We received a visitor at Wharton two years ago. He was a planner for one of the chief proprietary hospital chains and was encouraging us to do a study of the future capital needs of the health care industry, particularly the nonprofit sector. As the conversation proceeded it became clear that what this individual really wanted to do was get the nonprofit voluntary hospitals to recognize that they've got to charge more for what they do.

When you look at comparisons of nonprofits and the for-profits on a cost basis, you don't see a lot of difference. When you look at charges per day, however, you find the charges of the for-profits significantly higher for similar services. They put forth as their reason the need to generate margins to finance their tremendous capital needs.

Our visitor observed that the nonprofit sector has the same problem. They have great capital needs but refuse to build up significant

margins through the charge/cost differential. Rather, they keep charges relatively low and go to the debt markets for their capital needs. I assumed that this situation was hurting the for-profits in certain sectors of the country because they couldn't increase charges due to the pricing policies of the nonprofits who weren't out there increasing charges dramatically to build up the kinds of margins he perceived they needed.

Thus, his argument to us was why don't you do a study to show the nonprofit hospitals how much capital they need, and they'll get those charges up and then we can look more competitive and we can move into more communities, conceivably. I believe that was the unstated agenda. I found it kind of interesting.

Next Allen Hicks spoke on the Voluntary Hospitals of America. I must admit I don't fully understand the VHA but I have the impression their task is a difficult one because of the degree of cooperation required. If you have to get hospital executives at local institutions to put the good of the whole organization ahead of the good of their own hospital, as Allen suggested, you're not going to get very far it seems to me. And I don't even care if you do start a church, it's going to be difficult.

Then we go into governance issues, and I can go over this very quickly. Myles Lash and Fred Munson addressed hospital organizational structures and how well suited they are to coping with the new competitive environment. Myles Lash went through a litany of how competition will impact on the teaching hospital, and we heard them over and over, so I'm not going to repeat them for you.

There is one thing that he said with which I will disagree. He said that you would not have to worry about other people competing for the Title 19 patient. I really disagree with that wholeheartedly. There are going to be a lot of people that are going to want to compete for the Title 19 population. It depends on the state environment that you're in, but there is an awful lot of interest on the part of states to assign or direct members of the Title 19 population to certain providers that they view as low cost providers of care. The recognition is that if we incur \$60 a member a month for health care costs per Medicaid eligible, there is a lot of excess cost in that \$60 figure. The excess is reflective of the fact there is a lot of self-referral in the system, a lot of indiscriminate use, a lot of use of emergency rooms as a primary provider point, and there is a lot of use of high cost hospitals for routine services. Somebody willing to take charge of this population and manage their care more effectively could probably make a lot of money, even if they only got \$55 a member per month.

There are issues involved in enrolling Medicaid eligibles in a restricted program and issues of eligibility that everybody faces, but I suspect that in the near future you're going to find more competition for Medicaid patients than you might for other patients. The issue with HMO's not taking care of that population historically has been the great difficulty of contracting with state agencies on an acceptable basis for treating this population. The attitude of the

states is changing in this regard. You may say, "Good, let's share that population with other providers." On the other hand, what may be shared are the people in that population who may in fact be the lower utilizers. What's left for you as the safety net are the patients that really use a lot of care and are the very complicated kinds of cases that are under-reimbursed significantly.

Next, Dr. Munson talked about the university hospital study that I thought was really quite interesting. It's too soon to comment on what that study is going to produce, but I'm looking forward to it anxiously. The study is attempting to evaluate the ability of institutions to cope with their external environment and examines several variables that will impact on their ability to do that. Some of the variables being examined are an institution's internal structural clarity, as well as its local autonomy. How well does it control its own environment? The conclusion at this point in the study seems to be that we really don't see a strong relationship between organizational clarity, internally, and the ability of the institution to remain viable.

There are obviously other factors that are going to turn out to be quite significant in this "viability search" if you will, and I'm looking forward to what the study will produce in that regard.

I promised Delores Brisbon that I would say one thing about the nice little story Dr. Munson gave us at the end -- remember? About the hospital administrator, the once-upon-a-time story? That was really very entertaining, I thought. The one thing that we have to bear in mind is that hospital administrators don't always awaken from dreams and talk to their wives -- sometimes they speak to their husbands. Right, Delores? Then we heard from Karl Mangold, and we heard from Karl Mangold and we heard from Karl Mangold... I certainly remember "half the cost in half the time by courteous people." That I remember very well, and I think, despite the flair of the presentation that there were many things expressed by Karl Mangold that should give us cause for concern.

Perhaps there are people out there who are nibbling away at your foundation, and perhaps in a somewhat less flamboyant way. There are interesting phenomena going on that are impacting on teaching hospitals that I think are not being paid enough attention to by you. We'll get to that in a moment. It's also clear to me that I better polish up my CV, Karl, as well as all the folks in this room, because if those who can't do, teach, they're going to be after my job, right? I have to be careful!

One point made by Karl is a problem with a lot of the innovations in health care that are designed to save costs. This needs further discussion. I am speaking of health care costs in an aggregate sense at this point.

Most alternatives to inpatient care, I believe, are cost additive in the short run. If you take patients out of an emergency room and treat them in a freestanding urgicenter and if the cost of care is

\$80 and \$40 respectively, you haven't saved the system \$40. In fact, the system may have an added cost of \$40 when you get right down to it. The cost of maintaining the hospital's unused capacity will still be reimbursed by the cost-based payors and/or loaded into the hospital's charge structure.

I always feel in a very difficult position when I'm called in by some legislative committee or some insurance commissioner to testify on whether or not Blue Cross should be allowed to deny some freestanding surgery center status as a participating provider, and hence, reimbursement for freestanding outpatient surgical cases. Blue Cross will make the argument that "we're not going to recognize them as a facility because we don't need the capacity." Yet the freestanding surgicenter argues that it costs 50% as much to do a procedure in the surgery center as it does on an inpatient basis. How can I argue against the freestanding center? Well, my argument is, short run from a cost standpoint, it's going to add to total costs. The surgical capacity that's not used on an inpatient basis is still going to be paid for. Quality arguments aside, under cost-based reimbursement, a surgical service that's 60% occupied will cost almost as much to maintain as a surgical service that is 80% occupied. And all the costs are going to be paid for through cost-based reimbursement.

Looking long term, of course, if we let them happen, the pressure on capacity will diminish, and we won't build new facilities and we won't renovate and so forth. But in the short term, if you're looking to save bucks, those alternatives aren't going to do it for you. From the payor's perspective, it might be a nice alternative. But if I take the societal view and look at aggregate expenditures, capacity is going to be supported by some of us, indirectly, one way or another.

Next, J.D. Epstein spoke. It was getting very late in the afternoon, and I sensed a lot of restlessness in the audience, but I think he made some very important points. The most critical of them all was don't hop on the fad bandwagon. He said if reorganization makes sense, it will make sense not just because of this artificial contrivance called "reimbursement", but because it is a good business device overall. It's not a substitute for weak management, and reorganization and restructuring should never take place without an organizational assessment preceding it. That was the bottom line of what J.D. Epstein was saying, and I don't think there is any need to elaborate further.

What we heard Jeff talk about this morning was how the competitive environment within which we operate is organized. He talked about moving away from cost-based reimbursement towards more "brokered care". I think to some extent that is true -- perhaps more slowly than some people recognize, at least for your institution. Competition for patients is going to come anyway; it's here and it's been shown to be a good idea. Some people believe they can make money on it. That's the biggest incentive you need. As long as people believe they can make money, taking patients away from you and treating them differently, they're going to do it.

Another point made by Jeff was that health is not a growth market. I think one of the things that we have to bear in mind in the future

is that this pie, this health care pie, 40% of which hospitals get, physicians getting 20% of it and the other 40% going to dentists, pharmaceuticals, nursing homes and other services, is not going to grow as rapidly as the parties who share it want it to grow. This means that the size of the slices are going to start to change. Physicians are going to go after the hospital market, hospitals will go after the physician markets, and they'll both be going after that "other" market. Hospitals are not in the best position to fight this battle.

Jeff then took us through a list of the strengths and weaknesses of teaching hospitals. I thought he made five strengths out of two. The first four are essentially really related to your high technology, sophisticated tertiary kind of care. It dealt with things like class providers; you're the safety net, you're the final diagnostician, you're prestigious. You know, all those things is what you are. I think that's basically one major advantage, clearly. They're different but they largely stem from the same thing. The other advantage was that you train basically most of the physicians that are out there practicing, which allegedly builds loyalty and helps keep beds filled through referrals.

The weaknesses I thought were very acute. Who runs the place? It's really not obvious what business you're in. Costs are out of sight. You have an archaic delivery system in poor locations and you lack focus on consumers. Somehow I think the negatives outweigh the positives. You face some major problems in competing for patients in a more competitive marketplace.

Some of the strategies Jeff suggested were to push training out into the community, set up residents in private practices of one sort or another after their training like your competitors are doing, and understand your markets -- who you are serving and what product you are offering. He also suggested altering the internal reward structure. I'm going to say something about these in my closing comments, so I'll move on quickly to Bob Biblo.

I agree with what Bob said about negotiating with an HMO. I think all the points that he raised were valid. HMO's are looking to enhance their image. Their physicians are like any other physicians. They would like interaction with academic medicine and with teaching programs.

Bob addressed negotiating with HMO's in a general sense. I think there are a couple of things you should bear in mind when engaged in discussion with an HMO. There are some very positive aspects about having HMO patients in your beds. One is that if your ability to produce revenue is a function of your stock of beds, and given that your beds are relatively full, the way you enhance your revenues other than just increasing prices is by changing the mix of people that are in the beds. Shorter stays, more intense cases as opposed to longer stays, less intense cases. HMO's have shorter stays, more intense cases. It really provides a neater kind of patient from a revenue maximizing standpoint. Just from a dollar and cents standpoint, I

think that's interesting. They bring an attractive patient into the delivery system.

Secondly, while it depends on what part of the country you're in, you might have an opportunity to convert some patients from cost-based reimbursement to some better form of reimbursement once they get into the HMO. It doesn't follow that just because an HMO enrolls a Medicare patient that you get Medicare costs from the HMO for taking care of that patient. Or, if they enroll a Medicaid patient, it doesn't mean you're limited to Medicaid costs for taking care of that Medicaid patient. Or, if they enroll a Blue Cross patient, you're not necessarily going to get the Blue Cross rate for that patient. I think hospitals have been entirely too passive. They have reacted to the payor resources out there without trying to do something about the payors that are covering the people they treat. These are some of the advantages an HMO may offer from just a dollar and cents standpoint.

On the other hand, you have to be careful. You have to recognize that the kind of intensity that the HMO patient is going to present is going to be different than your average intensity. So you can't look at your average charges or your average costs and say that's applicable to the HMO patient. If the HMO is doing its job, within given diagnostic classes and within given services, you're probably going to have a more acute than average case. So, to give an HMO an average price might penalize you. There might be an intensity differential of several percentage points that is important to bear in mind.

A second thing to bear in mind is the dumping issue. If you're not going to get all of the HMO's patients, you're vulnerable to them dumping on you those patients that they can get cared for by you more cheaply than anywhere else. You could have a similar problem if you negotiated a global overall average reimbursement rate. You could end up with the most severe cases only.

In summary, there is a lot more to negotiating with HMO's than just a friendly relationship. There are real dollars and cents issues that have to be brought into play as well.

Now, one or two things before I let you go; and it's right at 11:30am. The last speaker, who we heard at lunch yesterday, was Donald Custis, MD of the VA who said, "Boy, if you think you got it bad, you ought to hear my story." It was really severe. Everybody's writing stories about the VA system. They hear that they ought to go out of business, they ought to become long term care centers only, they ought to mainstream their patients, and/or they ought to just go out of business.

If some of the current projections come to pass in the entitlement programs, by 1985 the VA is going to have almost a billion dollar shortfall in the revenues they need to run their system. That means essentially cutting 15 six hundred bed facilities out of the VA system altogether.

I already have made several of the points I wanted to make about HMO's. The fact is, as was stated by Dr. Buchanan, they're not a panacea.

They haven't shown that they can care for the poor. It was also stated that if only one HMO exists in an area, it doesn't help because their prices rise like hot air. Finally, it was suggested that there isn't significant evidence to show that HMO's do control costs.

Even though HMO's are not a panacea, I disagree with most of the specific points stated for the reasons that I have mentioned already. In my own employer's institution, if I wanted to sign up for one of the four or five HMO's offered to university employees, I would have had to pay \$40 or \$50 extra out-of-pocket for family coverage to join one of those programs two years ago. When the programs were offered again this July, enrollment in the most expensive HMO required \$20 additional out-of-pocket while the premium for the other HMO's was very comparable to the university Blue Cross program. I think the premium gaps are narrowing all around the country. In many cases, one can now get more comprehensive benefits for equal or less dollars although they are from more limited systems. HMO's are attracting patients and it's something that we've got to recognize.

I've already stated my views on competition in general and physician competition with hospitals. Going one step further, however, it's not going to be just doctor competition against hospital, it's going to be primary care doctor competition against specialists, family practice physician competition against internists, pediatricians and obstetricians, and it's going to be non-MD competition against MD's. I witness this competition in every community I go into to speak about HMO development. The battle lines are drawn immediately. In the traditional system, the primary care physician didn't care much what the specialist charged because Blue Shield paid both bills, and they guaranteed payment of both bills up to some limit. In the HMO scenario it's different. What one physician takes out of the system has a direct impact on what the other physician has available for him or herself. Participating providers tend to become very interested in what each other is doing.

Two final comments, one on reimbursement and cost containment and the other relating to your vulnerability ...

Let's take the second one first. I am concerned about the vulnerability of the teaching institutions. I think how well you do is a function of many important factors, only a few of which you have significant control over. Let's look at it in terms of how money gets into your cash register. Many sales take place before you actually receive payment for care. At each point in this sales process you are little more than a bystander. First of all, your revenue depends on how employers and unions design benefit packages, because in large part the design of those benefit packages establishes the purchasing power and the demand for your goods. Basically, nonproviders are deciding what benefits are going to be cut out of the benefit package next year and what's going to be put in, what limitations are going to be placed on inpatient reimbursement, etc. You hope that the decisions they make won't hurt you financially but you're really not part of

of that negotiation process.

Next, you're dependent to a large extent on which third party payors the employers and unions choose as their intermediary. If they choose Blue Cross, in many cases, you're less well off than if they choose Prudential. This is due to different reimbursement methods. You may do the same thing to the patient when they're in the hospital, but the money you garner for it is highly dependent on who the carrier is. But you're not part of that decision either in most cases. Some of you may indirectly influence the decision, however, because you give Blue Cross special deals which make them more attractive in the marketplace. You grant them concessions which allow them to attract patients from commercial carriers.

Next you are dependent on which primary care physician the patient chooses. Many of you don't have a lot of control over the primary care doctor choice, and you don't have that many primary care doctors in your systems to begin with. Then you're dependent upon the primary care physician's referral choices.

That's just the private sector. We can say the same thing about the public sector. You're absolutely at the mercy of the vagaries of the whimsical cost control strategies that the public sector may put in place. These strategies may include cutting entitlement, cutting benefits or arbitrarily changing reimbursement rules. All these factors influence the amount of money that enters your cash register and few of them are under your direct or indirect control.

One way to deal with some of these problems is to form your own integrated system of health care delivery and financing. I don't think you are capitalizing on the so-called "prestige" that you have. I would submit that there's a significant place in the market for closed systems of health care delivery that include teaching hospitals. I think there are a lot of people willing to pay the price for what they perceive as quality medicine. I really believe that, and I think it's up to some of you to put your reputation to the test; to try to capture a defined population. I don't recommend this as a defensive strategy but because it makes good business sense. If you enroll patients in a closed system, you no longer have to worry about benefit design, you designed the benefit program for them and they opted into it. Also, you are the third party intermediary, you are the carrier. Also, you control the referral patterns, because you're the system.

Historically, you have reacted to existing sources of payment and have tried to position yourself so as to capture the patients you want. You tend not to consider changing the way your patients are paid for. In the long run, you're going to suffer if you stick with fee-for-service reimbursement. If you have to do something in order to generate a dollar of revenue you're never going to get an extra nickle. You ought to migrate toward a payment system where you're paid for taking care of a defined population of some sort, where the good decisions that you make about efficiency and mode of delivery don't penalize you monetarily.

One final notion. I'm concerned about what competition is going to do to your patient flow. I think there are going to be plenty of patients to keep your beds full, but I think it's going to be a different kind of patient if you don't take any aggressive action with regard to who enters your institution. The volume will be there but the mix will be bad. What you're going to end up with is beds filled with aged and public patients that don't present the diverse kinds of cases that you need for teaching purposes.

Your teaching mission has attendant responsibilities. If 20% of the population is going to be enrolled in some sort of an alternative delivery system, I don't care if it's an emergency center or an HMO or whatever, we need to train physicians who can practice in these various delivery modes. For example, if we know we have 10 million people in HMO's and membership is growing at 10% a year, 800,000 to a million patients are being added to these alternative programs a year. If one full-time equivalent physician is needed for every thousand patients, 1,000 physicians a year are going to be absorbed by this delivery mechanism in one way or another. We're not really training those people anywhere now. It seems to me your institutions are duty bound to provide exposure to delivery settings that are alternatives to traditional fee-for-service medicine.

In closing, I would like to warn you about the AHA proposal for prospective reimbursement for Medicare patients. Any payment system that reimburses on a per discharge basis has the potential for dumping the most costly cases on the hospitals of last resort. Other providers will pick and choose the cases they wish to retain and will pass the others up the line. I envision a significant amount of over-reaching on the part of some hospitals under the AHA proposal. I have somewhat bigger problems with the proposal from an overall cost standpoint but this is not the time to address these issues.

Thank you for your patience.

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