WHAT HOSPITALS CAN DO ABOUT

the underfinancing of hospital service

by ROBERT M. SIGMOND

Ever since the advent of scientific medicine, the author states, hospitals have been underfinanced. Throughout this period, however, he points out, concepts of underfinancing have changed. The author traces these concepts and suggests a new emphasis including a program for hospitals in the current period of hospital finance.

PRIOR TO World War II, a hospital's underfinancing problem centered around its financial deficit. The implications of this situation were that (1) a hospital necessarily had to provide the very best of service to all patients in need of care; (2) these service requirements determined the hospital's costs; (3) after the hospital had collected as much as humanely possible from patients and "third parties," an inevitable financial deficit remained to be made up by the community through philanthropy and government grants. The indicated program for the hospital was difficult but clear cut: raise the money to meet the deficit.

The report of the Commission on Hospital Care in 1947 provided the first indication of the inadequacy of a "meet the financial deficit" approach to underfinancing.[1] This report outlined the broad service program that hospitals should make available, and suggested that the real hospital deficit was in the provision of needed services.

Seven years later in 1954, the Commission on Financing of Hospital Care presented factual analysis that showed the romantic quality of the "meet the deficit" approach and suggested a more realistic answer.[2]

THE SERVICE DEFICIT

These studies demonstrated that there is an inevitable gap between what medical science makes possible and what any hospital offers to its patients. As new medical discoveries are translated into new equipment and new kinds of skilled personnel to provide additional expensive services, there is a necessary and inevitable time-lag between each discovery and its availability in most hospitals. The CFHC found that as hospitals continuously attempted to narrow the gap between potential and actual service, the costs of hospital care went up.

The underlying reason for the rise in hospital costs—after allowance for inflation and improved salary levels—was found to be this steady broadening of the scope of hospital service resulting from advances in medical science.

Some hospitals had comprehensive relatively up-to-date programs of service. These had the highest costs. Other hospitals did not make available many services needed by acutely ill patients. These generally had lower costs. In both groups, most hospitals did not have financial deficits. Almost all of the hospitals, however, had some measurable service deficits.

Studies by the CFHC suggested that a hospital's expenses and service program—and therefore its service deficit—were largely determined by the availability of income. This is the reverse of the previous concept of a financial deficit resulting from shortage of income.

In most cases, hospital financial deficits represented minor or major errors in projecting anticipated income and expense. Rarely did they reflect a stubborn determination to offer a level of service that threatened bankruptcy for the institution.

NEED FOR PUBLIC EDUCATION

What were the implications of this analysis? Primarily, it suggested the need for a much greater degree of public understanding of the nature of optimum hospital service and of its costs. The public must be educated to accept rising costs in most hospitals as a reflection of ever better service. They must be helped to understand that failure to provide sufficient funds will not usually mean a financial

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This material is adapted from a speech presented at the 39th Annual Convention of the Michigan Hospital Association, Mackinac Island, June 1958.

Reprinted from
HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION
October 16, 1957—Printed in U.S.A.

deficit. Much worse, it will probably mean provision of less than first-class service.

To encourage broadening the scope of hospital services the CFHC recommended that hospitals be assured of adequate income through (1) support and encouragement of comprehensive voluntary prepayment and (2) government reimbursement programs for the indigent. At the same time, the Commission outlined a program for control of hospital costs to assure efficient use of every dollar spent.

HESITANT HOSPITALS HAMPER PLAN

After the CFHC report was presented, prepayment continued to grow rapidly and reimbursement programs for indigent care became somewhat less inadequate. Hospitals, however, were slow to develop a positive approach to rising costs. They hesitated to emphasize service deficits rather than financial deficits. There was concern that public confidence might be destroyed by knowledge that hospital service programs do not always measure up to the best available, and that philanthropic giving would decline if it became known that hospitals usually don't have deficits.

Nevertheless, it is my opinion that the public is eager for knowledge on the need for improvement of hospital services, and can find it more exciting to help overcome service deficits than financial deficits.

Recent efforts to increase public understanding of the interdependence of hospital income, service, and expense have been seriously hampered by the continuing rapid rise in hospital costs. Despite the best explanations of the desirability of rising costs and of the increasing efficiency of hospital management, the public today reacts favorably to statements from responsible and irresponsible sources that hospitals are poorly managed and are indifferent to the burden of hospital costs on the individual.

Why have hospitals not been more successful in convincing the public that they operate efficiently and in the public interest?

First, the public does not know enough about the extent of hospitals' efforts to control costs. Most hospital administrators—who spend nearly all their working hours controlling costs—find it almost impossible to understand that the public may suspect hospitals of inefficiency and waste of money.

The story of hospitals' efforts to control costs must not be thought of as merely "shop talk". The details must be told to the public over and over again, just as the necessity for higher hospital costs must be repeatedly explained.

The second reason why hospitals have not been able to convince the public of the efficiency of hospital service is that most of the public is not interested primarily in the institution's costs, nor even in the cost to the average patient served, but rather in their own out-of-pocket cost. This out-of-pocket cost is reflected today most commonly in the cost of a monthly prepayment premium. This premium is payable regularly in sickness and in health, and is usually paid by individuals who are not in immediate need of hospitalization.

In a comprehensive community-oriented prepayment program, the premium reflects the average

DIAGNOSIS OF AN INSTITUTIONAL AILMENT

The magnificent Ford Foundation grant to hospitals of $200 million was based upon a clear understanding of the true nature of underfinancing. The Ford Foundation's report, *The Difference It Makes,* states:

> **"It is easy to see why most voluntary hospitals are afflicted with an institutional ailment known among trustees and administrators as 'chronic under-financing'. The symptoms do not always show up in red ink. In fact, most voluntary hospitals manage to balance their books. Usually, though, hospital income from payments and gifts is barely enough to meet current operating expenses, and there is no money for adding or replacing facilities. The result is a deficit in hospital services.**
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> **"How large and how significant has the deficit been?**
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> **"A study of 1400 nonprofit community hospitals by an independent citizens' commission, operating under American Hospital Association auspices, reported in 1954 a serious lack of facilities: fewer than half of all short-term, nonprofit hospitals provided more than ten of nineteen selected services . . . The point is not that a hospital must offer all nineteen services or be rated inadequate. The survey simply revealed, rather impressively, but not surprisingly, that facilities frequently fall short of the ideal.**
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> **"There isn't a hospital administrator in the country who doesn't have in his desk drawer a list of urgently needed equipment and personnel . . ."** ■

monthly cost of the community's basic health program. It is this cost that concerns the public. It is this cost around which hospitals must center their attention.

SHIFT IN EMPHASIS INDICATED

In this current period, it is not enough for hospital representatives to be concerned with control of costs of their individual hospital's existing service program. They must also demonstrate primary concern with their hospitals' role in the broader program of control of the community's total costs of providing high quality hospital medical services.

It is no longer possible or desirable for hospitals to concentrate exclusively on attempts to identify the public with the needs and financial problems of each hospital. Rather, each hospital must give major attention to identifying its own program with the needs and financial problems of the public.

Pending this shift in emphasis, hospitals may expect a continuation of calls for more public representation on Blue Cross boards to "deal at arms length" with hospitals, and a continuation of proposals for government control of hospital costs and charges. Pending this shift in emphasis, complaints about the "high" costs of hospital care will receive a popular response no matter how well hospital representatives demonstrate their efficiency and the value of their services.

WHAT EACH HOSPITAL SHOULD DO

Specifically, what should an individual hospital do to meet this situation? First, it should thoroughly review its service program and plan indicated revision of it so that the hospital may be sure that it is efficiently providing health services that are really needed and that are not otherwise provided. The hospital should also review and revise its public relations program, but this should follow—not precede—the recasting of the service program.

An excellent guide for a review of a hospital's service program is provided by the report of the Commission on Financing of Hospital Care (as outlined briefly on pages 41-44 of the summary report). Five major items require emphasis in any such program review:

1. Elimination of duplication of services among community hospitals. Certain expensive facilities may be eliminated entirely in some hospitals by concentrating these services efficiently in a fewer number of hospitals. Admittedly, any proposal to accomplish this objective requires the development of new and extremely difficult relationships among the medical and administrative staffs of different hospitals. Nevertheless, the public will not believe that these relationships cannot be devised, especially in the absence of evidence that an honest attempt has been made. Efforts at regional coordination must be intensified.

2. Elimination of community health service gaps through increased utilization of the hospital's expensive specialized facilities, personnel and organization. Opportunities for unit cost reduction by increased utilization include new services for the chronically ill such as rehabilitation programs, service to nursing home patients, and organized home care programs; new services for the mentally ill; and preventive services including screening and health education programs. Addition of these services by selected hospitals will lead to greatest economy in provision of comprehensive health services for the community. Here again, however, extremely difficult area-wide coordination of effort is required—among hospitals and between hospitals and other health agencies.

3. Expansion and improvement of outpatient services in order to reduce unit costs of providing specialized services and to reduce the need for use of expensive and nonproductive inpatient bed and board facilities.

4. Elimination of any ineffective or "excessive" use of inpatient facilities by closer integration of physicians within the medical staff structure of the hospital and closer identification of physicians with the hospital and its program. Paul M. Densen's important study, recently published by the American Hospital Association, suggests that organization of group-practice units might lead to significant savings by reduction of inpatient utilization.[3] If this is so, the impact would probably be greatest where the group practice units were located at and organized in the hospital, as recently forecast by Julian P. Price, M.D.[4]

In any event, medical staffs should be encouraged to explore the feasibility of various mechanisms designed to promote effective use of hospital facilities and services, including admission review committees and medical economic audit committees.

5. Increase in hospital bed occupancy by reduction in number of beds available. In Michigan during 1956, for example, there was an average of over 5000 empty hospital beds throughout the year, or about one empty bed for every three in use. Conversion of much of this bed space to badly needed outpatient facilities could produce significant economies. Reduction in bed capacity might provide real opportunities for conservation of nursing personnel and improvement of quality of care by stabilization of the inpatient workload. With rising hospital costs, the public is probably more ready than many might believe to accept planned waiting lists for elective cases, and possible inconveniences of tighter scheduling of admissions and discharges.

These five suggestions—elimination of duplication, elimination of health service gaps, expansion of outpatient service, elimination of any excessive utilization, and increased bed occupancy by reduction in bed complement—are only illustrative of the elements of a thorough review of any hospital's program that is indicated by the current public concern about rising costs.

This suggested review and revision of the hospital's service program should tend to hasten the transformation of the hospital from an efficient institution for the care of acutely ill bed patients to an even more efficient center of community health activities, a role originally projected for the hospital by the Commission on Hospital Care.

NEW RESPONSIBILITIES FOR ALL

This change in the role of the hospital requires dynamic changes

in the responsibilities of the three major elements of the hospital: the board of trustees, the medical staff and the administrator.

- The trustee has traditionally viewed his position on a hospital board as an opportunity for community service by providing responsible leadership and guidance in the management of the hospital's institutional program. Today, the hospital trustee must increasingly assume the role of representative of broad public interest as contrasted with special institutional interest.

The trustee is in a unique position to ensure that the hospital reflects the needs of the public. As a nonprofessional in the hospital field, he can be more objective than the hospital's administrative or professional staffs in evaluating the extent to which the hospital is responsive to public needs. Intimately familiar with the inner workings of the hospital, his influence may be more constructive than that of other representatives of the public not directly associated with the hospital.

If the hospital trustee does not assume the responsibilities of a representative of the public, this role will inevitably be given by society to Blue Cross, state insurance departments, health departments or other branches of the state or federal government.

- The medical staff will need to recognize that the public's demand for economical quality care in a period of advancing medical science and advancing costs requires an even closer working relationship with the hospital. This is a time for less attention to outmoded legal fictions for artificially separating medical and hospital services, and more attention to invention of mechanisms for closer integration of an independent medical profession with the community's basic health agencies.

- The hospital administrator will need to be as concerned with community organization and professional coordination as with institutional management. He will tend to spend more time outside of the hospital and will require additional trained assistants. Within the hospital, he will find that the medical record department—rather than the accounting office alone—provides the basic facts for control of the costs of the hospital's program.

EXPANSION OF HOSPITAL COUNCILS

The suggested new emphasis in hospital service and cost control programs will require a great acceleration in group action among hospitals. Metropolitan and regional hospital councils can be encouraged to develop coordinated activities to help achieve the five-point program outlined above. Acceptance by individual hospitals of such voluntarily developed hospital coordination programs—even at the expense of some cherished "prerogatives"—is the only alternative to compliance with ever more specific government regulations.

In summary, hospitals have been and still are underfinanced. As hospitals have gradually become basic public service institutions, the solution to underfinancing of the individual hospital has shifted from an emphasis on meeting the financial deficit to an effort to demonstrate that hospital service is efficiently provided and that rising costs are in the public interest. Today, the current situation calls for re-evaluation and recasting of hospitals' service programs to assure that they are properly related—with other community agencies—to the needs of the public for comprehensive, efficient, high quality health services.

The cost of comprehensive health services will inevitably continue to rise. As costs rise, the time available to voluntary hospitals to retain leadership in the reorganization of hospital service programs grows shorter and shorter. ■

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AN EDITORIAL FROM HOSPITALS

—*the horse and the cart*

A welcome reaction to the telling of the hospital story would be: "I don't see how you can give us so much and yet charge us so little" or, even better, "why don't you charge us more and give us more."

We know of no cost-beleaguered administrator whose life has been made happier by such a comment. And the fault lies to some extent with all of us. Service underlies cost but when we talk about costs we usually embark into an elaborate explanation of them instead of putting the horse before the cart and detailing hospital services. We talk, as Robert M. Sigmond says in this issue of our Journal (page 34), of financial deficits rather than service deficits.

He points out that the studies of the Commission on Financing of Hospital Care suggests that "a hospital's expenses and service program—and therefore its service deficit—were largely determined by the availability of income. This is the reverse of the previous concept of a financial deficit resulting from shortage of income."

He argues, validly we believe, that "the public must be educated to accept rising costs in most hospitals as a reflection of ever better service. They must be helped to understand that failure to provide sufficient funds will not usually mean a financial deficit. Much worse, it will probably mean provision of less than first-class services."

We have to tell the cost story. But we must tell it in a framework of health services. Mr. Sigmond contends that the public can "find it more exciting to overcome service deficits than financial deficits."

Hospitals must continue their efforts to keep costs as low as they can in relation to the services they render. They must demonstrate, again and again, that they are doing that. They must destroy the shibboleth of the inefficiently managed hospital.

More importantly, they must encourage public understanding of what the hospital could be doing for the public if the public will underwrite the costs. Indeed, our attack is on the service deficit rather than financial deficit.