AN EVOLUTION OF HOSPITAL REGULATION: A PERSPECTIVE

by

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Hospital costs have remained a public concern during the last decade. As one delves into the discussion, a paradox quickly becomes evident; the hospital industry is becoming increasingly regulated while the economy in general undergoes deregulation.// What are the structural components of the hospital industry that might explain this course of events? What operational changes can be expected as the industry attempts to adjust to these newly intensified competitive pressures? How are other industries adapting to these changes and are there any instructive comparisons that might be made between these sectors and the health care field? A brief review of the history of the hospital industry is an illuminating first step.

It is important to remember that hospitals were operated as charity institutions until the turn of the century. In the late 1890's and the early 1900's, hospitals began to accept paying patients and were finally viewed as something other than a place of last resort. The primary goal of these early hospitals was to produce care at low or token cost. The notion of "quality" care had not yet been formulated.

Changes in medicine had a dramatic impact upon hospital's structure and upon their practice patterns. The three most important advances were; the discovery of x-rays, the use of anesthesia and finally infection control techniques. These changes meant that for the first time, the doctor was not a substitute for hospital care but rather a complement. The number of hospitals and beds increased rapidly after 1900 until a decline began in the Depression.

The Depression was the first major setback to the hospitals' continued expansion. Blue Cross was implemented as a partial solution to their dilemma. This program not only decreased the number of bad debts but also stimulated demand. One of the most important implications was that for the first time insurance reduced the out of pocket costs for medical care, and perhaps even more importantly, it illustrated the desirability of medical care. Nevertheless, it should be remembered that very few people had health insurance. Only 100,000 people were covered in 1938 which was less than one percent of the population.¹

Insurance benefits might have continued their slow steady increase except for one intervening factor: World War II. Wage controls instituted during the War meant that employers searched for methods to raise total employee compensation without changing actual pay levels. Employer paid benefit packages started to proliferate until by 1950, approximately 50% of the population had some sort of health insurance (primarily for hospital care). Coverage was not as comprehensive as the average policy sold

today, nonetheless, the number of people enrolled had leaped to 76 million in only 12 years.

The next big jump in demand occurred when the Medicare and Medicaid programs were initiated in 1965. Demand soared for hospital care, and as a result, the number of beds climbed 15% between 1965 and 1975.² Besides this concrete measure of change, these programs were important for two other reasons. First and foremost, it meant that health care had become recognized as a right. Secondly, and just as importantly, these programs provided the impetus for greater government involvement and regulations.

Previous government regulations were primarily concerned with general health and safety issues. Licensing requirements were made at both the state and local level. Accreditation was performed under a self-policing mechanism. Overall, these regulations were unconcerned with the cost or type of care provided, rather the focus was on the quality and competency of the care being rendered. These early programs are in stark contrast with the recent forms of government intervention. Planning, rate review, and Professional Standards Review Organizations (PSRO's) were all designed and begun in an effort to limit cost increases. Planning regulations included the establishment of health system agencies (HSA's) which monitored any capital expenditure above certain thresholds e.g., \$25,000. Rate review programs were sometimes voluntary as in Indiana while other times they were mandatory of whom Massachusetts is an example. These programs were often implicitly modeled after public utility regulation, which tried to reconcile the dual aims of maintaining a financially sound utility while providing universal service.

A fundamental question might be raised as to why the public utility model is even viewed as an appropriate role model. In the early 1960's, the idea first surfaced that hospitals should be treated as public utilities. Some hospital administrators saw public utility regulation as a method to convey a "special privilege" to a corporate body. Hospitals were seeking protection from "unfair" competition. Franchising was also viewed as a desirable alternative to possible forced nationalization. These administrators felt that hospitals and public utilities share the same crucial characteristics specifically:

1. served pressing public need
2. required expensive equipment
3. need to maintain peak load capacity
4. normally operated in a geographically controlled area
5. usual forces of demand and supply were unable to operate in the health care field due to the influence of insurance (patients do not pay the true costs of service)

It might be remembered that in the 1960's public utilities were not besieged with the pressures surrounding these companies today. Demand was raising during this period, while the cost of providing service was declining due to economies of scale. This happy combination of circumstances meant that regulators were able to lower rates because the increases in demand ensured that

utilities would still be financially secure. These halcyon days have passed for electric companies. Regulation is perhaps no longer the panacea that might have been desired for either the hospitals or the utilities. Furthermore, when the rate review programs were implemented in the 1970's, hospitals were faced not only with increases in demand but also in costs.³

If the first four reasons are no longer mentioned in current discussions of health care regulation, the lack of the medical marketplace is still viewed as a major stumbling block. One of the reasons that the marketplace is often assumed to have failed is the triangular distribution of power. Doctors, hospital administrators and trustees were all partners albeit unequal ones in hospital decision making. The consumer was often considered a powerless and passive participant in the system. Employers although paying many of the bills were not even considered to be an important component. Furthermore, the cost plus system of reimbursement meant that insurance companies simply paid the bills forwarded to them by the hospitals and physicians. Although most people had obtained their insurance through their employers, rarely were medical bills monitored except for actual fraud. However, recently a new distribution of power has emerged. Hospitals, physicians and payers (governmental and nongovernmental) are the new participants and the payers are striving for control. New methods of reimbursement such as the Diagnostic Related Grouping (DRG) plan of Medicare have been the recently brandished stick of the payers.⁴ Ironically, because of deregulation, some formerly regulated firms now find themselves facing the same operating hazards as hospitals. What lessons applicable to the health care field can be gleaned from these other industries.

The banking industry is not only competing with their conventional Saving and Loan rivals but also with a host of new players in the financial services market. In 1980, Congress ordered a phase out of ceilings on interest rates that banks pay on small savings accounts. Limitations on interstate banking have also been falling. Results? Today the banking industry faces intense competition from "non-bank" banks. Over one million people have started using Merrill Lynch's cash management account which combines checking, saving and credit cards into one account. Sears Roebuck intends to set up a national network of banks and the company is already involved in insurance, brokerage, savings and loans as well as the real estate business.

The effects of these changes have not all been positive. Customer service charges have on the average doubled since 1980. Economists have estimated that the cost of loans has increased by one percent since banks must now pay more for the money which is being lent. Moreover, the increased costs of deposits and intensified competition for customers have meant that banks have experienced both lower profits and revenues since the early 1980's. A symptom of these problems is that regulators have approximately eight hundred banks on a problem list, in addition to the seventy banks which failed last year.⁵ This situation is similar to hospitals who have recently faced competition from some entities that are either new to the field or in the case of

insurance companies, previously played complementary roles not competitive ones.⁶

The telephone and telecommunications sectors have also experienced wrenching changes in the last few years and some of these shifts are similar to those experienced by hospitals. Instead of one company who manufactures and distributes services, there are now over 200 manufacturers who only produce phones. Four hundred companies now sell long distance service. There are both positive and negative aspects of this new environment. Many customers are confused by the more complex billing system. In addition, they face a loss of one stop shopping, as well as higher costs for equipment installation and service.⁷

Problems are also arising for the phone companies. It seems likely that eight separate companies will probably never function as well as one combined corporate body. Furthermore, both AT&T and the regional phone firms face an uphill battle within their respective companies. All of them must change their company perspective from being service oriented regardless of the cost, to a profit and marketing oriented approach.⁸ Adjustment has been a slow and painful process for all these companies.⁹ As in the hospital sector, AT&T has had a continuing series of layoffs since the breakup. Regulators and the phone companies must also determine a way to revise their rate schedule so as to continue universal service and yet keep local residential and business rates at a reasonable level. Bypass is a distinct possibility. Companies and other large entities, e.g., universities, might "bypass" the local phone company and build their own system. For example, Boeing Company evaluated a plan to implement its' own 70,000 line private network in Seattle, which in essence would mean that Boeing would have become the twenty-fifth largest telephone company in the United States. Pacific Northwest Bell, in the meantime, would be deprived of millions of dollars in annual revenues. This would mean that the remaining customers would be forced to shoulder a much larger share of the fixed costs associated with phone service.¹⁰

In the health sector, Hospital Corporation of America (HCA), American Medical International, Inc. (AMI), National Medical Enterprises, Inc. (NME) and Humana, Inc. have all recently unveiled plans to begin selling insurance. The programs being offered are not the traditional forms of insurance but rather preferred provider arrangements where members are steered to certain channels of care (NME and AMI) as well as forays into health maintenance organizations or HMO's (HCA). These companies have gambled that these organizational structures are the most likely to prosper in the upcoming years.¹¹ They are not oblivious to the fact that HMO membership has surged from four million in 1977 to fourteen million in 1983 representing a two hundred and fifty percent increase. Some project that by 1990 one out of every nine Americans will be an HMO member. This suggests even more declines in hospital admissions since a recent Rand study has shown that HMO members may have admission rates as much as forty percent lower than non-members.¹² It should be no surprise that all of these new plans are designed for direct

marketing to employers as companies attempt to "bypass" hospitals and physicians except as components of their plan.

As suggested above, the hospital sector is not the only group within the health industry who had to make major adjustments in recent years. Physicians are at a crossroads. Declining office visits are simply a symptom of their problems. One of the ways that doctors are attempting to combat these problems is by signing up for sessions on marketing and management.¹³

What is the impetus behind this change? A major force is the increasing supply of doctors. The number of physicians has jumped from 348,000 in 1970 to 487,000 in 1981; in just ten years, there was a forty percent increase.¹⁴ Independent practitioners, in particular, are feeling pressure from health maintenance organization's (HMO's) as their enrollment continues to rise. Some doctors have joined either IPA's (Independent Practice Associations) or PPO's (Preferred Provider Organizations). This allows them access to more patients while still maintaining their own private practice.

What are some of the results of the new competitive pressures facing hospitals? American Hospital Association data shows that forty-three percent of all U.S. hospitals expect to layoff workers in the next few years. In the last year alone, ten to twelve and a half percent of all hospitals experienced some layoffs. Additional changes may be forthcoming since some experts feel that it is only a very short period of time before the government sets joint fees for doctors and hospitals.

One solution might be for hospitals to take the initiative and establish closer ties with physicians. Some hospitals, e.g., Des Moines, are already setting fees which include both physician and hospital care. Doctors in Houston, Texas have banded together and bought stock in their health care system as a method of instituting a PPO type of organization. Businesses in the area will buy a health care package which includes ambulatory care centers and a selected pool of physicians. This system also allows patients to view a schedule of all charges including physician fees for hospital services. Employers, in the meantime, are publishing a list of approved facilities and providers.¹⁵

What is the future of hospital care? The number of both hospitals and beds will continue to decline. Those hospitals who hope to weather the storm until the "good" days return will find themselves further and further behind their competitors. While becoming a low cost producer is a necessary first step, those hospitals who survive will have found some way to distinguish themselves from other choices for care. Thus, they must convince consumers that they are "desirable" hospitals to use. There will be more than one hospital on most provider "approved" lists and the consumer along with his/her physician will still be choosing from among these institutions. Hospitals must find ways to differentiate themselves from their competitors.

Hospitals are accustomed to thinking of themselves as service organizations but in the general sense. Emphasis on hospitality types of services may be one way that a hospital distinguishes itself from other providers. It may also be

necessary to offer more types of service beyond the traditional inpatient care such as day care for the elderly.¹⁶ Hospitals like the other industries discussed cannot hope to return to easier times, those that adjust the fastest will be the ones who are in existence to meet the next challenge.

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