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WHO RUNS THE HOSPITALS?

by Edward T. Gluckmann
Co-founder and Board Member
The Consumer Commission on the Accreditation of Health Services

Every year labor-management welfare funds pay billions of dollars to New York City area hospitals either indirectly, through Blue Cross and commercial insurance carriers, or directly through self-insurance. Many funds have trouble collecting enough in contributions to pay for hospital coverage. The cost of hospital care keeps climbing, and many hospitals have average rates of more than $500 a day.

Today, hospitals have the power and resources to affect jobs and establish labor policy in other industries and to affect housing, education and other aspects of community life. Fund trustees, who are legally bound to disburse fund dollars solely for the benefit of fund participants, are now joining individuals, corporations and consumer groups in questioning hospital operations, the delivery of services in their community, patient rights and the cost and quality of hospital care. Who makes hospital policy and who decides how to spend the dollars generated by today's hospital rates?

All hospitals in New York receive their authority to operate from the State. New York City has its municipal hospital system, and there are approximately 30 proprietary (for-profit) hospitals in New York City and Long Island. The largest group of general care hospitals is known as "voluntary" hospitals. These non-profit, tax exempt institutions provide short term in-patient care and out-patient and emergency services. In 1980 voluntary hospitals had about 66% of the almost 47,650 general care beds in New York City and Long Island, and accounted for 95% of the approximately 259,600 discharges from all hospitals in that area. Voluntary hospitals also provide about five million out-patient visits each year.

The legal responsibility to set hospital policy, run the hospital and make all major decisions rests with each hospital's governing board. Board members do not actually carry on the day to day operations; that function is delegated to administrative and other professional personnel who manage the hospital. The important questions about these boards are:

- ► Who are the people serving on voluntary hospital boards?
- ► Whom do they represent?
- ► Whose interests are they serving?
- ► How do they get on the boards?

Historically the governing boards of voluntary hospitals distributed their own and their wealthy neighbors' money to provide charity care for the poor. Today everyone uses hospitals and almost everyone, through taxes and insurance premiums or direct out-of-pocket payment, helps pay for hospital services. Blue Cross and commercial health insurers plus government programs like Medicare and Medicaid, now pay for well over 90% of hospital care. Self-insured labor-management health and welfare funds, commercial insurance, Workers' Compensation and self-pay patients provide virtually all the rest. By the most recent statistics available, philanthropic and private contributions (including donations from board members, grants, legacies, community chests, etc.) now represent less than 1% of hospital operating income, and less than 10% of total funds for hospital construction. More than 20% of all hospital construction costs for short term hospitals are financed through commercial bank loans, many of which are guaranteed by the government. Whether guaranteed or not, interest on the monies owed banks by hospitals is passed along to individuals and third party payers through hospital reimbursement rates.

Who are the board members, and how are they selected? While the nature of voluntary hospitals has changed, the composition of their governing boards has not. The boards generally include only persons who have achieved economic and social distinction, usually business and professional men who represent religious and educational institutions, foundations and the very wealthy. Existing board members choose their own replacements, so that the boards are self-perpetuating. There are almost no minorities, a small percentage of women and only a handful of labor officials. Business leaders who serve as trustees of welfare funds are rarely invited to serve on hospital boards. Working people, consumers and the community are basically not represented.

Although New York State grants the legal power to establish hospitals and outlines board responsibilities, it does not require full disclosure of board membership or identification of potential conflicts of interest. The Consumer Commission on the Accreditation of Health Services created a sensation in 1973 by publishing the names of the board members of most voluntary hospitals in the metropolitan area, along with their records of meeting attendance and number of years of service.

The democratization of voluntary hospital boards is long overdue. In many different ways, the public pools its resources to pay for hospital care. The public has a right to know who decides what to do with this money, in whom the public trust is being placed, and how good a job they're doing of it. New legislation would be needed to require hospital boards to include representatives of the community and

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MEDICAL TECHNOLOGY AND CORONARY ARTERY DISEASE

by Arthur A. Levin, M.P.H.

With the current proliferation of medical technologies, it is inevitable that more than one technology may be considered appropriate for diagnosing or treating a particular condition. Such is the case with the current state of medical practice in treating coronary artery disease (CAD).

In CAD, blood flow to the heart is restricted by stenosis (narrowing) of one or more coronary arteries. Reduced blood flow produces the classic symptoms of arterial disease—pain and shortness of breath during exertion. There is ongoing discussion and debate as to whether treatment with drugs or with the surgical technique known in the trade as "cabbage" —coronary artery bypass graft surgery (CABG)—produces optimum results.

Several large scale studies have been done to determine whether there is any difference in outcome between CABG and drug treatment. It has been clearly demonstrated that for those people with stenosis of the left main coronary artery, the surgery dramatically reduces the incidence of sudden death compared to drug treatment. However, only about 10 per cent of those with arterial disease have left main stenosis. The results of long term studies as they affect the other 90 per cent are what is being discussed and debated.

Some believe that the studies, and clinical experience, have shown CABG to be the treatment of first choice. Others argue that it should only be done if drug treatment has not been successful. Both treatments relieve the symptoms of the disease, but some surgeons argue that CABG prolongs life. Some studies have shown that people feel better after CABG; other discovered that people do not increase their levels of occupational or recreational activity after the surgery.

The debate has gone on for some time, which is not unusual. What is unusual is that the debate has excluded a non-surgical treatment technique, less invasive and less costly than CABG, which may well be underutilized for non-medical reasons.

The third option is known as percutaneous transluminal angioplasty (PCTA). In conjunction with angiography, a catheter tipped with a deflated "balloon" is inserted into the affected artery to the site of the narrowing. The balloon tip is then inflated to reduce the obstruction. Cardiovascular monitoring is required for up to eight hours afterward, and hospitalization can last from one to three days after the procedure.

PCTA is not a curative technique, but it does provide relief of the symptoms associated with reduced blood flow. The safety of the procedure in comparison with CABG differs depending on the condition of the patient and the artery(ies) involved. PCTA is done under local anesthesia, and so avoids the complications inherent in opening the chest and using a heart-lung machine. In those with single vessel disease and who have never had CABG, the operative mortality of the two techniques is the same. There seems to be increased risk for those patients who have had prior CABG. Whenever PCTA is performed, there is a CABG team on standby. Emergency CABG is required for 6 to 8 per cent of PCTA cases, and mortality rates under these conditions are higher than for elective CABG. Some researchers report encouraging results in clinical trials of PCTA for multi-vessel disease. Experts are hopeful that improved (stronger) balloon tips and greater practitioner experience will lead to even better results in the future.

There are striking contrasts between the costs of the two techniques. A 1982 study sponsored by the American Heart Association found that PCTA averaged about one-third the cost of CABG, including physician fees and hospitalization. Physician fees for PCTA ranged from $3,300 to $8,000 with a mean of $4,800; for CABG they ranged from $10,400 to $25,000 with a mean of $15,000. Average length of hospital stay for PCTA was four days, while CABG averaged twelve days.

The same study showed that there are significant differences in ability to work after the two procedures. Eighty per cent of PCTA patients were able to go back to work promptly, with their workweeks averaging 40 hours. Only 70 per cent of CABG patients were able to resume working right away, with workweeks averaging only 34 hours. One year after treatment, PCTA patients lost 25 per cent of their work time to illness; CABG patients lost 45 per cent.

If PCTA is a viable, effective technology for treating arterial narrowing and is as safe, less invasive and less costly than CABG, why did it take so long to become accepted and why is it less widely accepted than the surgery even today?

One reason is that most people with arterial disease are sent to vascular surgeons for an opinion. This has a major impact on treatment selection. Surgeons like to practice their craft. They are comfortable with their own methods, know the risks and believe in the outcomes. They may find it difficult to believe that a non-surgical approach can be as effective. They may not be well informed about the development of non-surgical technologies.

The slow acceptance of PCTA may also be the result of how medical practice is organized and financed. A large amount of money is at stake for those performing and supporting coronary artery bypass surgery. This year, more than 3.5 billion dollars will be spent on CABG. There is considerable financial pressure on vascular surgeons to operate—their fees for CABG

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Editor: Donald Rubin
Associate Editor: Roxanne Young

EVERYONE BENEFITS

by Louis L. Levine
Corporate Vice President, Public and Governmental Affairs
Blue Cross and Blue Shield of Greater New York

It seems that there is widespread misunderstanding and misinterpretation of the relationship that Blue Cross and Blue Shield of Greater New York has with its participating hospitals. The differential in hospital payments that the State has seen fit to grant us is based, not on favoritism as is often implied, but on recognition of the advantages that accrue to the whole community through our unique activities. Our efforts benefit not only our own subscribers but all purchasers of heath care—self insured funds as well as commercial insurance carriers.

We are all aware of, and concerned about, the rising cost of health care. What many are not aware of is the contribution by Blue Cross and Blue Shield of Greater New York in keeping the rate of increase from being even higher than it is.

The fact that we cover over 9 million people in the area and have been providing hospital coverage for nearly 50 years, puts us in a unique position to have a positive influence on the overall cost of health care in the area, *for everyone.*

By way of illustration, I'd like to focus on just one area in which our activities have generated demonstrable results—Utilization Review.

No program of health care cost containment can be effective without the ability to track specific costs and to identify patterns of care. Only through in-depth claims review can inefficient, inappropriate or ineffective delivery of services be identified and corrected.

Hospital claims received at Blue Cross and Blue Shield of Greater New York are examined for appropriateness of treatment, length of stay and necessary services before payment is made.

A focused review of medical records is performed by professional nurses and physicians to insure that hospital services are being utilized appropriately. In addition, statistical profile data are shared with hospitals and studied to determine if inappropriate patterns of care exist in the form of pre-operating days, discharge delays and unnecessary admissions.

Blue Cross and Blue Shield of Greater New York then works with the hospital to establish mutually acceptable criteria of cost management.

As a result of our joint efforts with hospitals we have developed a unique program for the benefit of our subscribers, called *Due Care/Hold Harmless.*

This program is an important step in the ongoing development of the Blue Cross and Blue Shield quality assurance and utilization review program. It builds upon the existing utilization review and quality assurance programs of Member Hospitals and upon the programs currently in place at Blue Cross and Blue Shield. In addition, the *Due Care/Hold Harmless* program also responds to the urgent concerns of purchasers of health insurance for the effective review of health services provided to employees and other constituent groups. More than 90% of the hospitals invited to participate in the program have done so.

The *Due Care/Hold Harmless* program has two major objectives. One is to promote and strengthen the utilization review and quality assurance programs of the Member Hospitals resulting in the improved quality and cost effectiveness of care. The other is to protect the individual patient and the participating hospital from economic loss for occasional utilization errors involving Blue Cross subscribers.

The *Due Care/Hold Harmless* program will hold eligible Blue Cross subscribers harmless from financial liability for days of care in participating hospitals when the Plan ordinarily would decline payment because:

- The care was found to be medically unnecessary; or
- The utilization of hospital services failed to meet basic standards of appropriateness and efficiency.

The program gives participating hospitals financial incentives to strengthen their controls on the quality and medical appropriateness of the services they provide to Blue Cross subscribers by:

- Rewarding institutions that meet or exceed established standards for utilization review and quality assurance; and
- Penalizing institutions that fail to meet basic standards in utilization reivew and quality assurance.

It is Blue Cross and Blue Shield of Greater New York's conviction that the *Due Care/Hold Harmless* program will make a significant contribution to the quality and cost effectiveness of care received by subscribers at participating hospitals. The elimination of services that are medically useless or harmful, and the improvement of efficiency in the scheduling of needed services in accordance with standards of patient care management established by recognized clinical leadership, are bound to be beneficial to the patients' health and to their economic well-being.

Activities such as these and numerous others have resulted in more than $140,000,000 of direct savings to our clients during 1980 alone. And in another, more dramatic set of statistics—fewer and shorter hospital stays for those insured by Blue Cross and Blue Shield of Greater New York, and a slowing of the rate of increase in medical costs in the area.

It is because of our commitment to improve the quality of care and contain costs for all of the public that we have the differential in hospital payments. The greatest inducements that hospitals have to keep a rein on costs come from the active involvement of Blue Cross and Blue Shield of Greater New York.

Were we not in a position to ultimately affect costs, a strong incentive would be removed and hospital costs would soar to even higher levels.

Medical Technology

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range in the $5,000 to $10,000 category. This pressure is implicit in the decision to operate rather than to refer the patient to a radiologist for PCTA.

Several other factors affect the choice of a technique for treating coronary artery disease. First, CABG is already widely used. There will be more than 180,000 such operations performed this year. The prevailing attitude about medical practice seems to be, if it works why change it? Second, the risks of CABG have been reduced and outcomes improved as experience has been gained with it over the past decade. Third, the drug management picture is improving. New drugs such as the calcium channel blockers or antagonists have been shown effective, and better versions of older drugs such as beta-blockers are being developed. Including PCTA among the treatment choices adds even more confusion to an already cloudy picture.

It is estimated that at least 15 per cent of those patients undergoing CABG could be treated with PCTA instead. In order to avoid the problems of practitioner bias described above, multi-disciplinary second opinion panels must be established. Such panels would include not only vascular surgeons but also cardiologists and radiologists. Together they would carefully analyze the individual history and prognosis, and reach a consensus on what treatment would be most effective, safest and least costly for a given patient at a given time. Insurers who are paying 3.5 billion dollars for 180,000 CABG procedures in 1984 may find this is the only way to rationalize the choice of technologies and produce better outcomes.

Arthur A. Levin is director of The Center for Medical Consumers and Health Care Information, Inc.

Who Runs the Hospitals?

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third-party payers. In the absence of a change in state law, labor-management health and welfare fund trustees can devise other strategies to place equitable numbers of their representatives on each hospital board as full voting members. This would offer a unique opportunity to help control the hospital and medical costs that are draining welfare fund resources.

With a voice in determining hospital policy, trustee representatives could improve cost and quality controls. They could influence the development of regionalized technology. They might deter the construction of new facilities that add to a hospital's prestige without being medically necessary. More involvement by labor could also reduce the chances of a hospital board undertaking policies unfavorable to labor, the community and third-party payers. Perhaps, too, these experienced trustees could help to avoid the tragic consequences of such labor-management disputes as the one that recently led to the longest hospital strike in New York City's history.

Health and welfare fund trustees have learned over the years that there are many areas of common interest to labor and to management. Serving as representatives on voluntary hospital boards would expand those areas while providing skilled and caring expertise for hospitals at the policy-making level.

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