HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

VOL. IV, No. 2 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. March-April 1977

Pub. 6/77

NATIONAL HEALTH SERVICE II

Over 80 million Americans annually are eligible to receive part or all of their medical care through government programs. In 1975 over 42% of the total expenditures in health care was paid for by government. Since the introduction of Medicare and Medicaid in 1965, the government's financial and regulatory involvement in the health sector has increased significantly. With this growing involvement, without demonstrative improvement in the quality or distribution of services, more people are expressing interest in a nationally organized health system as the best way to ensure quality care at a reasonable cost.

The Jan.-Feb. 1977 issue of HEALTH PERSPECTIVES ("National Health Service I") presented an overview of the major weaknesses in the organization of medical care delivery, most of which are caused by the support of and belief in the profit-making private sector of medicine. The Commission suggested that a national health insurance program would exacerbate current problems by pumping more money into the health delivery system without effecting needed changes in the organization, distribution, quality and accessibility of care. Increased financing without basic change would reinforce the monopolistic and oligopolistic profit-making aspects of the health industry and would only continue and worsen the problems it seeks to solve. "National Health Service I" argued that a national health service administered by publicly accountable bodies is an alternative working model. Regional organization of health care provided and regulated directly by the federal government using a salaried corps of professionals is a logical way to organize health care. The development of a national, socially directed health delivery system which guarantees public accountability would provide all Americans with quality medical care at a reasonable cost regardless of an individual's ability to pay.

Many important issues in planning, resource allocation, implementation and regulation of medical care are raised by a proposal to create a national health service. The transition to a national health service from the present system which emphasizes acute care provided on a fee-for-service basis requires that changes be made in the structure of the relationship between individual and institutional providers, consumers and government. This issue of HEALTH PERSPECTIVES reviews the relationship between the government and the providers of health care in publicly funded programs, the contracts between these parties, and the ability of government to enforce provider contracts. A national health service requires clarification of the responsibilities of health providers and government to consumers and the establishment and enforcement of meaningful standards by public agencies.

GOVERNMENT THE SHIRKER

Government's basic mission is to protect the public. As if this were not a strong enough reason to exercise control over the quality of health services in the United States, government has the additional responsibility, as does any other large scale purchaser of goods and services, to demand accountability of its supplier. However, the federal government, which in some other areas makes that demand, has repeatedly decided not to fully exercise its authority when purchasing health services. Via a complicated set of political, legal, moral and ideological precedents government has failed to exercise its rights and responsibilities to monitor and control the quality, cost and availability of the health services it purchases.

LAW AND NO ORDER

The traditional laissez-faire (no government interference) policy advocated by the private health care sector has long been institutionalized in federal legislation. Federal interference with the private practice of medicine is specifically prohibited in Title XVIII (Medicare) of the Social Security Act Prohibition Against Any Federal Interference (Sec. 1801):

> **"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee or any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."**

This section limits the ability of the federal government to exercise its responsibility to assure the general welfare of the nation. The philosophy behind this prohibition has prevented the government from guarding the public's purse, health and interest. Title XVIII allows health institutions the choice of doing business directly with the government or with a fiscal intermediary of its choice which then acts as a middleman between the institution and government. Hospitals usually choose fiscal intermediaries rather than having to deal directly with the government. Blue Cross plans, originally set up by hospitals, are the most frequently designated intermediaries. The establishment and enforcement of cost and quality control standards and procedures have also been left in the hands of the providers or their agents. The Medicare program pays hospitals for their reported costs, with no control over those costs. Hospitals have been granted the privilege to use the Joint Commission on the Accreditation of Hospitals (JCAH), which is supported and controlled by hospitals and other providers, to certify them for participation in the Medicare and Medicaid programs. There are no public officials or consumers on the JCAH governing body!

The federal government has failed to accept its responsibility as advocate of the public's interest in health care. Because of this failure, federal dollars continue to subsidize poor care, wasteful practices and unethical arrangements—all at extravagant cost to

the public. The government has a moral obligation to ensure that whatever health services it purchases are not harmful to the public's health or pocketbook. Health care is a service that cannot be regulated efficiently by the free market. The government, working outside the free health care market, must determine how and under what conditions health services are to be provided. It must begin more forcefully to exercise its considerable legal, political and economic powers to control the health industry. By accepting its responsibility, government can begin to revamp health delivery in the United States into a system which provides quality care at reasonable costs.

SELECTING PROVIDERS

CURRENT SITUATION: ALL WELCOME

Congress was concerned that not enough providers would be willing to participate in the Medicare (Medicaid) program when that program was being formulated in the early 1960's. Today in many places there are more providers than are needed to serve Medicare beneficiaries. A recent report prepared for HEW entitled *Reducing Excess Hospital Capacity* indicates that nationwide there is an estimated 20% excess in the number of hospital beds. These extra beds could be reduced without endangering the health of the American people.

There have also been reports that over three million patients undergo unnecessary operations each year. Many hospitalized patients could be treated on an ambulatory basis at a lower cost. These findings are confirmed by the lower hospitalization experience of consumers enrolled in pre-paid group practice health plans in the United States. If national hospital admission rates were reduced to those of pre-paid group practice programs, the excess number of hospital beds might soar as high as 50%. Other countries which have experienced lower hospital utilization rates have limited or eliminated fee-for-service financial incentives to provide unnecessary hospital care while concurrently limiting the number of available beds in relation to the clinical needs of the population.

Currently, *any and all* providers meeting minimal standards are accepted into government funded programs and are entitled to receive government reimbursement for the provision of services to covered patients. It is the health providers who choose to join government programs rather than the government which chooses the appropriate providers for the services it is purchasing.

The fear that there would be a shortage in the number of providers interested in participating in government programs has proven to be unfounded. The situation today is rather that the government must begin to seek ways to match the number and kind of providers more closely to the needs of consumers. This matching process can only be successful by applying the criterion of need against the available resources and by depending more on consumers and less on providers in determining how that need is to be met.

SELECTING INSTITUTIONS BASED ON NEED

The development of a national health service necessitates the selection of health providers based on the needs of the population. The government now provides or pays for the health care of many millions of Americans. With the establishment of a national health service the government will be paying for almost 100% of the costs of health care. This major undertaking requires government action to ensure appropriately distributed, accessible and efficient, quality services. In order to accomplish this, only those providers and services which are necessary to meet the public's actual health care needs should be accepted in the national program.

Determinations of acceptability to participate in public programs based on publicly derived standards find precedent in some government programs and in numerous private arrangements. The criteria for a national health service which will build on this conceptual precedent must contain more stringent quality and cost controls and uniform, equitable and publicly accountable enforcement procedures. Consumer needs for appropriate health care services in their region rather than the demands of providers must be the basis for determining the services to be included in a national health service and in any transitional national program.

CLOSED PANEL: A NEW (OLD?) IDEA

Doctors presently provide medical care on their own terms. No one can direct doctors to practice in areas where they are needed, at an affordable price or in a system not to their liking. Many patients blindly select a doctor who is convenient or who was referred. Most doctors charge for each service provided and will limit, if not totally refuse, to provide care to those who cannot pay. Until very recently, most doctors worked alone in private office practices usually seeking admitting privileges at several convenient hospitals in which they were able to use institutional resources free of cost.

The alternatives to this private practice, fee-for-service system include prepaid health care plans, group practice and closed panels. Prepaid medicine simply means that the patient pays a fixed fee (usually on an annual basis) to cover all the charges for a predetermined range of services. These covered services, which generally include all routine medical care, are provided at no additional cost to the patient. Group practice means that more than one doctor works in the office. Groups can include many specialties (medicine, surgery, pediatrics, obstetrics, gynecology, etc.) or several doctors providing one type of specialty care. Most of the more successful pre-paid group practice programs have been developed by industry and trade unions. Closed panels are lists of individual doctors who are chosen because they have met established criteria and have agreed to contractual conditions of participation. These criteria can include medical and continuing education and training requirements, staffing levels, physical plant, processes of care and administration, productivity, fee schedules, etc. These arrangements already exist in the private insurance field where panels of participating providers have been established and benefits are paid only to those providers.

On a national level the Medicare and Medicaid programs can be seen as a type of closed panel. There are conditions of participation and standards to be met by providers in order to qualify for government reimbursement for the care of covered beneficiaries. The conditions of participation in these programs, however, are broadly written, standards are extremely vague, and enforcement has been lax.

In contrast to these national programs, private closed panel arrangements with incentives and controls specifically geared to restrain costs while maintaining if not raising the quality of medical care, have been notably successful.

PANEL MEMBERSHIP: STRICTLY CONTRACTUAL

In a national health service and any transitional program an explicit contractual relationship between government and health providers must be established and enforced. A typical contract must specify:

- —an effective date, a termination date, a notification date to renew, modify or terminate the contract;
- —the terms and method of computing compensation, the services and conditions under which services are to be provided;
- —the due process procedures to be followed when government seeks to terminate the contract while it is in force;
- —definition of "cause" under which the contract can be terminated;
- —definition of patients' rights and the degree of public accountability required of providers;
- —requirements concerning continuing maintenance and/or upgrading of skills by providers;
- —penalties for failure to provide services as specified;
- —performance standards and methods to review quality;
- —grievance procedures to be followed by providers and consumers when abuses are alleged.

The participation of providers in a national health service must be based on their continuously meeting and abiding by government rules, regulations and procedures. Failure to do so must be considered "cause" for the imposition of penalties and, ultimately, for termination of the contract. It must be clearly stated that no property rights ensue from the privilege of participation.

A STEP IN THE RIGHT DIRECTION

A positive move away from the historical government position of non-interference in health care delivery was taken in the writing of PL 93-641, the Health Planning and Resources Development Act of 1974, which expands the role of government in the health industry. Since PL 93-641 superceded the Comprehensive Health Planning Act of 1966 (PL 89-749), which did contain restrictive language similar to that contained in the Medicare Act, PL 93-641 represents significant progress toward philosophical and political acceptance by government of its responsibilities. It also creates a precedent to remove all restrictive language in the future. PL 93-641 suggests that government is finally ready to exercise its power to protect the public's interest.

EXPANDED HSAs: THE LOGICAL CHOICE

Two hundred local Health Systems Agencies (HSAs) are currently being established and staffed under the National Health Planning and Resources Development Act of 1974 (PL 93-641). Thus an organizational framework already exists to review and select needed providers. HSAs are charged with the responsibility of developing regional health systems plans. In order to develop these plans, HSAs have the authority to review each institution in the community and to determine the proper role, function, and interrelationships of these institutions. The governing body of each health systems agency must include 51-60% consumers who represent the demographic characteristics of the region's population. Therefore, consumers now have the potential to influence deliberations and to force needed organizational changes in their region.

HSAs have the responsibility to constrain the expansion or development of new unnecessary institutions. However, they do not have the power to control the continued operation of existing unnecessary and/or poor quality institutions. For their authority to be meaningful in the determination of which health care institutions are actually needed to serve the region's population, this authority must be expanded to include existing, as well as proposed new facilities.

Under PL 93-641 HSA designation can be given to either a government or a non-profit voluntary agency. Most of the developing 200 HSAs are voluntary, i.e. private, corporations. Although, with the expanded authority to determine the appropriateness of existing provider institutions HSAs will become the logical bodies to be responsible for the selection of providers for a national health service, in order to insure that these HSAs more clearly serve the public's interest, they too must be reconstituted as public bodies and the balance of representation on their governing boards must be changed to require more consumer and public members.

In the selection process, institutions which are not determined to be needed because they deliver poor quality care or because there is an excess supply in the community will not be included as providers in a national health service in that area. Limiting participation to institutions deemed appropriate will reduce the number of beds, services and providers of care. This is the first step to achieve government control of health providers.

EMINENT DOMAIN FITS HERE

In order for government to be able to use hospitals to implement national and regional policy and become responsive to community needs, public ownership of hospitals or control of their governing bodies is required.

There is a clear cut solution to the problem of how to obtain public ownership of proprietary institutions which are needed in a particular community. Proprietary hospitals are private corporations or partnerships organized to make a profit under corporate or partnership law. Based on the Constitutional principle of eminent domain, the government can purchase the corporation or partnership's assets and capital at a fair market price. Eminent domain gives the government the right to acquire property which will be used for the public good. As land or property acquired under eminent domain has been used for libraries, schools, highways, etc., there is precedent for its application in the health field.

Voluntary or non-profit hospital corporations are created by law for the purpose of providing charitable services. These institutions do not earn profits for any individual, and based on their status as charitable organizations, they are subsidized by government and individual contributions. Today, government subsidy pays for more services and facilities than do the contributions from all private individuals. Financial support (tax-free contributions) from governing board members of these hospitals is even less. Government pays for services, research, facilities, equipment and, in addition, grants non-profit tax-exempt status. The theory underlying tax-exemption is that the ultimate contribution by the charitable institution to the public good returns more than a fair equivalent for this subsidy. The services provided by non-profit institutions are held to be a public benefit, the cost of which would otherwise have to be borne by government. For over 30 years the government has contributed substantially to the construction of many hospitals through the Hill-Burton program. Practically all of these institutions continue to be reimbursed by government through publicly funded programs and subsidized by various government research and training grants. Public funds now cover more than half of the operating expenses of hospitals.

Voluntary institutions which began as public benefit corporations have evolved into organizations which exercise control over the dispersion of vast amounts of public money and resources although they continue to be run by governing bodies composed of private individuals. These governing bodies are composed primarily of wealthy, white men who often use their influence to help their institutions circumvent or ameliorate the effects of government regulation. Generally, governing board members neither represent nor are accountable to the local community or the

This is the second in a series of issues in which the Consumer Commission is examining the need for a national health service capable of providing equitable and quality health/medical care services to all the people in the United States without regard to their ability to pay. The Consumer Commission is interested in your ideas and opinions on this subject, and shall consider the publication of supporting or opposing views in future issues. Articles forwarded to the Consumer Commission for consideration should be between 500-1000 words.

EXCERPTS FROM *LONG-TERM CARE REGULATION: PAST LAPSES, FUTURE PROSPECTS—A SUMMARY REPORT*, MORELAND ACT COMMISSION. APRIL 1976.

"1. POLITICAL ACCOUNTABILITY: On the major issue...the quality of care rendered in nursing homes and the cost and profitability of nursing homes and other institutions rendering long-term care...no one in a position of leadership in the state effectively shouldered responsibility or sufficiently monitored developments in the public interest.

These failures of oversight and responsibility took place despite the fact that institutional long-term care is one of the single largest government programs in the state. Government picks up most of the tab—$1 billion yearly in Medicaid reimbursement alone flows to nursing homes, health related facilities and ancillary providers of care. The regulatory role of government is both critical and central to a fair and effective system of care.

But until relatively recently poor care rendered in all too many of the state's nursing homes and other long-term care facilities and excessive profits earned by many operators simply had not become political "issues." Ultimate accountability for government regulation of the quality of care in institutions and for the massive flow of government funds rested with a political leadership which expressed no abiding and forceful interest in these matters...

2. POLITICAL INFLUENCE: Despite their neglect of the elderly, there has been a constituency in the nursing home area to which politicians have carefully attended. This constituency, the owners and sponsors of facilities, has known what it wants with great clarity, has sought favor upon favor, and on many occasions has actually hired politicians to pursue its interests...

Nursing home owners and sponsors inevitably will seek political influence to obtain a public franchise or to maximize reimbursement from public funds. In seeking loans from the public treasury or in protecting interests in a flow of public reimbursement for services, not-for-profit institutions have become as skilled as private entrepreneurs in searching for political advantage and support... Politicians must draw a line between the role of "ombudsman"—insuring, for example, through inquiry that bureaucrats are properly performing their assigned tasks—and abusing the public trust by exerting excessive and undue influence on regulatory processes...

...(T)he problem (focuses on) the ability of private clients to hire legislators as lawyers to represent them in proceedings before state regulatory agencies. Legislators pass on the budgets of regulatory agencies and adopt laws affecting these agencies. Their presence as counsel for a private client cannot help but be an intimidating presence on agency personnel. ...(T)his situation can(not) be anything but hopelessly compromising for both legislators and for regulatory bodies...

3. BUREAUCRATIC INEPTITUDE: ...The failure of regulation of nursing homes and other facilities must be ascribed in large measure simply to the inability of the bureaucracy to adequately define its mission, to fashion appropriate regulatory tools and, most importantly, to pursue its role with determination. For the most part, the Commission found that regulatory performance of state agencies in long-term care has been so meaningless, unworkable and unsound as to allow the continuation of poor care, patient abuse and high profits without resort to "political channels"...

4. LAX ENFORCEMENT: The New York Department of Health, with central regulatory authority over nursing home and health related facilities, has been furnished by legislation with a wide array of enforcement weapons. Poor care and patient abuse in homes throughout the state were known to department officials for many years. However, the department's enforcement efforts were so timid that until 1975 no fines were levied for "operating deficiencies," no operating certificates or Medicaid provider agreements were revoked for such deficiencies, and not a single nursing home administrator was stopped from renewing his license on grounds of patient neglect or abuse. Strict enforcement of existing care standards was not forthcoming until public attention was focused on nursing homes in late 1974 and in 1975...

5. MEASURING QUALITY OF CARE: The Health Department—and also, it should be noted, the Department of Health, Education and Welfare...have not...taken the essential first steps, which are to determine what is important to regulate in nursing homes, and how to measure what is important...

Nursing home regulators have never developed explicit definitions of "acceptable" care, have not devised instruments to measure whether care rendered in homes is acceptable and have not been able to formulate refined tactics and strategies to enforce acceptable care standards. Thus, for example, in survey inspection efforts of the Health Department, altogether too much attention is placed on items that are immediately measurable—whether facility personnel hold the right qualifications, whether staff ratios meet code standards, whether myriad forms of paper work are completed and properly signed, and whether facilities meet provisions of the Hospital Code with respect to corridor widths, room size and many other structural requirements. None of these capture what is essential: whether care rendered is acceptable or not...

6. REAL ESTATE BONANZA: Unintended but nevertheless extraordinary profits were reaped by nursing home real estate entrepreneurs through misrepresenting costs. But extraordinary gains were also garnered simply by following the complex rules established by the Department of Health to reimburse property costs. Reimbursement for such costs under the Medicaid program now amounts to approximately $120 million annually.

Excess profits could be obtained by misrepresenting building costs or the costs of financing; by misrepresenting sales as being between unrelated parties to increase reimbursement; or by not reporting costs and obtaining rental amounts at ceilings established by the department. The massive job of auditing costs, a necessity under the department's complex system, was not undertaken in a serious or systematic fashion...

7. PURCHASING CARE IMPRUDENTLY: In setting reimbursement rates for operating costs of nursing homes, the State Health Department has adopted a "cost related" system. It has depended for its integrity on the completeness, accuracy and truthfulness of cost reporting and on comprehensive auditing of cost reports. But all too often, cost reports from nursing homes have been incomplete, inaccurate or deliberately false. Auditing has been grossly insufficient...

8. ASSESSMENT AND PLACEMENT: Undermining many regulatory efforts is the near total lack of monitoring and control over decisions affecting the placement of individuals in homes. State regulatory agencies have failed to define explicit rules and to implement effective procedures to determine which patients or residents might require the most expensive "skilled nursing" level of care, which might require "health related" care, and which can be successfully cared for in domiciliary facilities...

9. BUILDING BOOM: Fostering construction of new nursing home and other long-term care beds is one task that state regulatory agencies performed expeditiously. The centerpiece of the Rockefeller administration's effort in nursing home matters was the use of moral obligation tax-exempt bonds under the Article 28-A program for the construction of not-for-profit homes. Since the inception of that program, 17,600 beds have been built with $570 million in public mortgage loans. These facilities were lavish. ...(H)ad Article 28-A facilities been built with the average economy of construction achieved in the proprietary sector a total of more than $500 million in interest and amortization would be saved taxpayers over the next several decades...

10. "CONSUMERS" HAVE BEEN LEFT OUT: It has become increasingly apparent... that the nursing home industry has faced little pressure from "consumers" of its services...

Official channels of redress also must be opened to patients and their families if only to counterbalance the inevitable political influence that operators and sponsors will seek to obtain...

...(O)pinions of patients or residents be sought as an integral part of surveys and inspections of homes. Current inspection efforts inexplicably ignore the entire dimension of patient satisfaction..."

general public. During the transition to a national health service these institutions must be brought under public control. As was suggested in the Fall 1976 CCAHS QUARTERLY entitled "HSA and Governing Bodies—Conflict or Complement", this can be accomplished by requiring as a condition of participation in publicly funded programs that a majority of the governing board members be representatives of the community, the local HSA, the institution's workers and public officials.

By invoking the right of eminent domain, government throughout our history has exercised its right to determine when public interests take precedence over private property rights. In health care the needs of the public must also be given priority over the interests of private institutional providers.

THE FOLLOWING SECTION OF *HEALTH PERSPECTIVES* DISCUSSES PRIVATE AND PUBLIC ROLES IN ESTABLISHING AND ENFORCING STANDARDS AND PROBLEMS WITH PRESENT PROCEDURES TO CURTAIL OR TERMINATE INADEQUATE PROVIDERS.

RESOLUTION AND REDRESS

The establishment of a national health service requires government health agencies to become more effective in the regulation of the health care industry. Government must have greater responsibility, authority, and political support to regulate and monitor health care in order to protect the public. A move away from inadequate regulations, lenient standards, lax enforcement and peer review, toward meaningful standards, strict public enforcement and use of external, unannounced audits is needed.

Effective, coordinated government regulation is necessary prior to government ownership or direct control of health care institutions. The findings of regulatory agencies will be the basis for recommendations to maintain, upgrade or eliminate institutional providers and recommendations about the amount, types, and distribution of providers. The regulatory agencies will continue to monitor all providers in or out of the national health service. The regulations and enforcement mechanisms will be established nationally and only modified to meet special local conditions.

STATE REGULATION: A MINIMAL AMOUNT

In 1974, while 200,000,000 Americans spent over $104 billion on health services, all 50 states spent only $62 million on institutional and individual provider regulation. The latter amount is slightly more than one million dollars per state, or less than 1/1000 of the total national health bill.

And, as some states spent more than one million dollars, the rest spent even less. The fluctuation in expenditures reflect a tremendous variation in state enforcement efforts. The comparative paucity of the amount spent by all is indicative of the weakness of this effort.

The philosophy that government should not be involved in the regulation of medical care persists despite the recognition that regulation is necessary. This philosophy, coupled with the concentrated political power of medical providers, has subverted the intent of health statutes and regulations to protect consumers.

STANDARDS

Participation in the Medicare and Medicaid programs is initially based on the meeting of minimal standards (i.e., licensure or accreditation) and subsequently on passing inadequate on-site surveys which historically emphasize structural design and fire safety procedures. Inspectors look at the physical plant, administrative memos, minutes, medical committee structure and purpose and governing body activities. They review everything except the process of direct patient care and its outcome.

Nursing homes are required to abide by regulations covering the education of the administrator, the presence of nurses, the administration of drugs, the availability of physicians and Life Safety Code standards. Fulfillment of these minimal requirements is accepted as *a priori* evidence that an acceptable level and quality of care is being rendered. The standards assume that an adequate physical environment means acceptable care and a less adequate physical environment means poorer care. Not only is there no evaluation of the quality, cost or effectiveness of treatment but institutions are notified well in advance of an inspection so they can prepare to pass. (For more information on the pitfalls of present accreditation and survey techniques see previous CCAHS HEALTH PERSPECTIVES and QUARTERLIES on this subject.)

NURSING HOME REGULATION

In most states regulatory agencies are charged with broad responsibilities but have little power to effectively enforce their decisions. In New York State, however, the Moreland Act Commission in its April 1976 *Long Term Care Regulation: Past Lapses, Future Prospects—A Summary Report* found that the state's nursing home regulation program suffered not from a lack of power but more for the reasons listed in the box on page 4.

NURSING HOME TERMINATIONS: WHOSE RIGHTS COUNT

Government regulatory agencies most frequently cite and take action on Life Safety Code deficiencies in nursing homes. Recommendations to terminate participation of a particular nursing home in the Medicare or Medicaid programs are usually followed by time-consuming appeals before government agencies or the courts. These appeals are usually brought by nursing home owners (or operators) who claim that the proposed government action violates their rights.

The extent of the rights of nursing home operators to continue to be paid by government to render care when the nursing home is potentially dangerous to its patients (the supposed beneficiaries of the government program) is an issue of considerable importance. When faced by government action intended to require nursing homes to meet standards or lose their right to receive government reimbursement their operators have claimed that their interests in retaining Medicare and Medicaid reimbursement constitutes a "property" right. Therefore they contend that they are constitutionally entitled to receive government payment until all due process procedures are exhausted. These claims have on occasion been upheld in court. Under present regulations nursing home operators (and all other health providers) are afforded extensive hearings and reviews before they can be decertified and the government can take action to appoint a receiver (in New York State), transfer patients or terminate reimbursement.

Other court decisions have found that nursing home owners do not have an inherent property right in Medicare and Medicaid payments. In these cases the relationship between government and nursing home operators has been defined as a contractual one between a purchaser and seller of services. Thus this relationship is controlled by contract rather than by constitutional law. In one New York State case the court held that a provider agreement was only a contract which created no inherent right of extension or renewal and that the state had no legal obligation to review an expired agreement with a nursing home which had failed to correct deficiencies within the time limit prescribed in the agreement.

The rights of patients to reside in safe nursing homes or to be transferred to one providing the level of care guaranteed by statute has infrequently been a decisive factor in court decisions. The courts have been reluctant to infringe on the property rights of nursing home operators. Unless there are extraordinarily dangerous or unsanitary conditions existing, noncompliance with standards by nursing home operators is not usually considered sufficient grounds for the courts to order the transfer of patients or the termination of payment of government funds. Administrative actions by government to eliminate public financial support for these homes are therefore often not supported in the courts. Legal precedent does not clearly support the removal of patients from dangeorus nursing homes or denial of funds to those facilities—even to save lives!

The opinions and needs of patients are not usually taken into consideration in the process of terminating a nursing home or hospital from participation in government programs. Often patients and their representatives are in an even better, and with

patients certainly more intimate, position than government officials to know the positive and negative effects of the care being provided in an institution. All hearings to terminate provider contracts must require comments from patients and/or consumer representatives. Government must not only solicit patient and consumer input at hearings but must also guarantee patients protection against retaliation for their testimony.

The transfer of nursing home patients should not be done precipitously. The severe emotional and psychological problems which are a normal effect of such transfers must be taken into account. It is important that all safeguards be maintained to protect the health and safety of the nursing home's patient population. (The problems associated with transfer trauma and the ways to prevent needless suffering and death are outlined in CCAHS QUARTERLIES "Nursing Home Transfer Trauma—Part I" and "Nursing Home Transfer Trauma—Part II".)

HOSPITAL ASSESSMENT

4,500 of the over 6,700 general hospitals approved to participate in Medicare have been certified for participation by the Joint Commission on the Accreditation of Hospitals (JCAH). These 4,500 hospitals represent about 90% of the total number of hospital beds in America. As is now required for nursing homes, the 2,300 non-accredited hospitals are subject to inspection by a state health agency using federal standards.

The JCAH standards applied to hospitals are similar in nature to those used for nursing homes. They are primarily geared to the structural and organizational aspects of the hospital. There is little external audit of the quality, cost or effectiveness of services.

HOSPITAL TERMINATION

Authority to terminate a hospital from the Medicare program because of non-compliance with the federal conditions of participation is delegated to the HEW Regional Medicare Directors. This authority is limited by the fact that the JCAH's survey reports of the 4,500 participating hospitals are confidential and not readily available to government officials. (They are not available to the public.) This secrecy causes the unnecessary expenditure of time and energy in the process of validating JCAH certification, hospital review, and, where indicated, the subsequent termination of a hospital from federally funded health programs. (For example, complaints filed by the Consumer Commission against a number of non-complying hospitals took over two and a half years of review before the Regional Medicare Director was convinced that enough information was available to make a determination.) In the last three years, HEW terminated only 27 short-term general hospitals, only four of which had over 100 beds, from participation in Medicare. (For details of the JCAH accreditation process, see HEALTH PERSPECTIVES, Vol. II, No. 2, Mar.-Apr. 1975, "Hospital Accreditation: Where Do We Go From Here?")

The priorities in hospital accreditation, monitoring, and enforcement are similar to those in the nursing home industry: the rights of patients and society are secondary to those of the providers.

REDRESS: THE PRINCIPLE OF DUE PROCESS

The Constitution of the United States states that no citizen shall "be deprived of life, liberty, or property, without due process of law." Basically this guarantees the existence of procedural safeguards to protect citizens against arbitrary or capricious determinations by government. Due process of law is a basic tenet of democratic philosophy and of our political system. However, as with many other self-evident principles, discrimination and abuses occur in its application. As Sylvia Law indicates (see box entitled "Due Process: Use and Abuse") due process procedures have different affects on different people. For welfare recipients, in the instance of termination of payments, due process is swift and routine. On the other hand, when poor people seek welfare benefits, the availability of redress through due process hearings is often used as a rationale to deny benefits. Benefits continue to be denied until the due process procedure winds its way to closure often months later. In contrast, for health care providers due process entails time consuming layers of administrative hearings and court procedures before any punitive action can be taken. In fact government benefits and funds continue to flow to them unabated during the process. Furthermore, the cost to institutional providers of due process hearings are paid for by the government through Medicare and Medicaid reimbursement. It is only when the process has reached completion, frequently years later, that government can move to terminate the flow of public money to protect the beneficiaries of public programs. The lives of patients is threatened when due process places property before life or liberty.

The implementation of the principle of due process can lead to swift or time-consuming procedures. Depending on who is being heard due process can be used as a tool or a weapon. The principle is not at fault because of its discriminatory application.

DUE PROCESS: USE AND ABUSE

"The problem with due process lies not in the principle, but rather in the way the principles are applied. Contrast due process for welfare recipients with due process for doctors and nursing home owners (proprietors). Since 1968 the Supreme Court has held that when welfare is denied or terminated the recipeint has a constitutional right to a due process hearing. Did the states respond to this requirement by throwing up their hands and saying if we must provide poor people with due process we will never be able to cut ineligible people off the welfare rolls? You can bet not. States learned what due process requires—in the case of termination, notice and an opportunity for a hearing before an impartial hearing officer—and due process is routinely provided. Sometimes due process is used as a weapon against poor people. For example, case workers frequently deny poor people benefits which the worker recognized the person is entitled to receive, saying "if you don't like it take a fair hearing". The poor person can then seek a fair hearing and weeks or months later will receive the benefits that they should have been provided in the first place. Fair hearing delays are unconscionable, and more significantly, no mechanism exists for reprimanding workers who habitually deny people benefits to which they are entitled. These workers cause enormous injury to poor people, and also cost the state a lot of money in providing hearings which would not have been needed if the worker had done what they knew the law required in the first place.

Contrast the situation of doctors and nursing home operators. In New York State the law requires 19 separate administrative processes and two levels of judicial review before a doctor's license can be suspended for incompetence or fraud. This means that doctors can continue to practice and injure people for months or years while the process winds its course. The constitution does not require this much "due process" for doctors. It is simply that doctors are politically powerful and have persuaded the state to give them layer upon layer of administrative process. The situation with respect to nursing homes is similar. When a nursing home is denied the right to participate in Medicare or Medicaid the Constitution requires that it be given notice of the reasons and an opportunity for a hearing. But that is *all* that is constitutionally required. Oftentimes courts and administrative agencies will respond to political pressures to keep a nursing home in Medicare. "Due process" is often offered as an excuse by an agency that does not want to do the work or encounter the political hassal necessarily involved in excluding a substandard home from Medicaid or Medicare."

—Sylvia Law

author of *BLUE CROSS: WHAT WENT WRONG*

PRIVILEGE IS NOT A RIGHT

In the transition to a national health service the notion of provider property interests in public monies must definitively be put to rest. Participation in government programs is not a right but a privilege. The provider must meet certain contractual requirements which are binding on both government and the provider. Breach of the terms must be followed expeditiously by the imposition of penalties as stated in the contract and followed by inspection to ensure the rectification of deficiencies. Termination of the contract, the ultimate penalty, should be approached keeping the needs of patients in mind.

Responsibility and public accountability demand that an identifiable body in each region be legally responsible to monitor providers. Standards and enforcement procedures must be devised and uniformly applied. Failure to meet standards must be linked to enforceable penalties. Consumer input at all stages and at all levels must be built into the monitoring and enforcement process.

END IS JUST BEGINNING

Escalating costs, uneven quality, secrecy, scandal, irrelevant standards, poor monitoring, inaccessibility and drawn out court cases over property rights of providers point up the need to convert the nation's health system into a rationally planned, controlled and regulated resource. The transition from private control to a socially responsive health system will resolve these problems. This new venture requires written enforced contracts, salaried physicians, publicly controlled governing bodies, effective HSAs and a commitment by government to govern. All are prerequisites to a national health service.

IN SUMMATION....

The establishment of a National Health Service in the United States clearly requires a tightening of governmental controls of the quality and cost of medical and hospital services. Greater governmental expenditures and more direct government involvement in the rendition of health care inevitably call for more stringent regulations because no responsible government can justify major spending programs without adequate controls.

The present system has demonstrated an increasing need for effective monitoring of the quality and cost of care. Under the present reimbursement system of Medicare and Medicaid, the approval of hospitals as providers of reimbursible care is largely left to the Joint Commission on the Accreditation of Hospitals, while the entry of physician providers into the system is left essentially unregulated as to quality—any licensed physician, and any board-certified specialist is an eligible provider. Thus, in the instance of hospitals, state licensure aside, the qualifying and monitoring functions have largely been delegated to a private association which is itself composed of provider representatives, while in the case of physicians, state government controls. The initial state license is good for life unless a physician is found in serious violation of the state's medical practice act. Until very recently, the only control on the performance of physicians was the paternalistic overview by the physician's own medical societies, and the very limited control provided by state medical boards, generally composed of physicians, understaffed and quiescent. The evaluation of the quality of the physicians' services has recently been delegated to the newly developed Professional Standard Review Organizations, an elaborate system of regional peer review organizations, limited, however, to the performance of the physician in a hospital setting and not in an office practice.

A system of review and analysis of costs is available in consequence of the computer audit of Medicare and Medicaid, which may also provide some insights into aspects of quality control by providing information on the kind of services reimbursed. The system is flawed, however, by the circumstance that with respect to Medicaid, quality and cost controls may be divided between different agencies, with cost the responsibility of social welfare and quality the responsibility of health agencies.

The recent history of Medicaid and Medicare abuses and scandals indicate that professional fields are not temptation-proof when enough government money is at stake. A National Health Service, which will probably operate both by reimbursement of service rendered by providers and by direct provision of health care, requires that our present rag-tag "system" of controls be overhauled. Ultimately, direct federal controls, direct federal monitoring of cost and quality will be necessary. Such direct federal monitoring by way of inspections, surveys, and other resources of quality control are not necessarily inconsistent with peer review—a physician's performance, and the performance of professionals generally, should be assessed by another qualified professional. The notion of peer review need not be rejected—physician's work should be reviewed by physicians, as long as the reviewing physicians are in the employ of, and responsible to an appropriate regulatory agency. A different question is presented by cost controls, which, dependent on good planning and decent accounting and auditing procedures, are strictly matters of regulatory control, and not much of an argument for peer review is possible. Indeed, the consumer's voice is as relevant here as it may ever be.

Sound regulatory controls are not only a matter of sound law and sound organization. There must also be a will to enforce, a commitment to the idea of enforcement. Such a commitment needs as yet to be demonstrated.

Frank P. Grad
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The Labor Safety and Health Institute has published *An Occupational Safety and Health Workbook* to be used as a practical resource to medical and public health practitioners, trade union education programs, students of occupational safety and health and others with responsibilities for the administration of occupational safety and health programs. This *Workbook* is currently available from the Consumer Commission at $4.00 per copy.

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THE ACCREDITATION OF HEALTH SERVICES INC.
381 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959

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