Hospitals in New York City Balk at Drive on Unneeded Surgery

By DAVID BIRD

Fearing a loss of patients and revenues, more than half the hospitals in New York City have been resisting — and in some cases openly defying — a year-old state regulation aimed at preventing unnecessary surgery.

Known as utilization review, the regulation promulgated last year by the State Health Department required each hospital to draw up tighter standards for admitting patients for surgery and for keeping them in the hospital after operations. Its proponents said it would reduce hazards and costs.

All the state's hospitals drew up the required standards, but most have not lived up to them. This resistance has been stiffened by the American Medical Association's opposition to utilization review.

It was a state program, but it was backed by demands from the Department of Health, Education and Welfare that the states make sure that Federal dollars put up to match state funds were well spent. Government funds are now the major source of hospital income.

Highest Surgery Rate

The Federal concern grew out of such facts as that the rate of surgery was the highest in the world and growing. One Federal study said that unnecessary surgery had risen to the point where it was estimated to cost almost $4 billion and more than 11,000 lives a year.

By last July all the state's hospitals had drawn up utilization plans that were acceptable to the State Health Department. But later last year when the state checked to find how the plans were being implemented in New York City hospitals it found that more than 60 percent of the city's hospitals—69 out of 117—were not living up to the minimum standards of their plans.

In some cases the opposition was very strong.

Dr. John L. S. Holloman Jr., the president of the city's Health and Hospitals Corporation, wrote a memorandum to all of the executive directors of the city's municipal hospitals directing them not to implement the new plan.

Many hospitals have been reluctant to plunge into a stringent utilization review that might cost them money because they might have more empty — and thus nonrevenue-producing—beds.

"We're in a little bit of a power play," said George Kalkines, the Health and Hospitals Corporation's general counsel, in explaining why the municipal hospitals are not putting the new utilization review in effect. "We want some money up front to implement the plan and then we will comply."

Mr. Kalkines said putting the plans into effect would require a staff of several people in each hospital, and the municipal hospital system, which is cutting its staff sharply because of the budget crisis, is in no position to add more personnel.

"Every time I want Holloman to do something he says he hasn't got the money," said Dr. J. Warren Toff, the State Health Department's associate commissioner for New York City affairs. "But we just can't hold patients in a hospital for a long time when we're paying $215 for every day someone stays in a municipal hospital."

Medicaid, which pays hospital bills for the poor, is the main outside source of income for the municipal hospitals. Half of Medicaid's cost is paid by the Federal Government. The other half is shared equally by the state and city. But while the state has a large stake in paying hospital bills here, it has not been able—or willing, some critics charge—to exert much power in demanding that the money be spent wisely.

Review Suggested

Warning letters went out late last year to all the 69 hospitals that had failed the inspection. Each letter was accompanied by a report on the deficiencies found.

"I suggest you review that report," said the form letter from Dr. Toff to each of the 69 hospitals, "and institute the necessary corrective action immediately."

Dr. Toff's letter told the noncomplying hospitals that another survey would be made "after Jan. 1, 1976," and that failure to comply on the resurvey "may result in fiscal sanctions against the hospital."

So far there have not been any fiscal sanctions nor any resurveys. State health officials say it is not their fault. They say the Federal Government is backing off on utilization review.

As medical costs increased in recent years state officials said they were given to understand firmly that hospital costs must be controlled. But in the last year, they say, there has been confusion.

In earlier years, state officials said, there was little uncertainty about what was wanted by Secretary Caspar W. Weinberger, who until last year headed the Department of Health, Education and Welfare, which controls Medicaid payments as well as those under Medicare, which pays hospital bills for the aged.

Do It or Else

"It was crystal clear with Weinberger," said one high State Health Department official, who asked that his name not be used because he must still deal closely with H.E.W. "What was clearly understood was, 'You will do it [enforce utilization review] or you will be fined.' Now they seem to be saying, 'Do something to show that you're doing something, but don't be too tough!'"

Although strong utilization review was championed by the Weinberger administration, which took a strict view of the Congressional mandate to make sure that Federal money was not wasted, suits by the American Medical Association have been a strong factor in forcing H.E.W. under the present Secretary, David Mathews, to back down.

When H.E.W. originally put forward its new utilization proposals in January 1974, it required that a patient be certified as needing hospitalization before he arrived at the hospital.

After receiving what H.E.W. described as "voluminous public comments," the agency eased the final requirements so that a patient could be admitted to the hospital before the utilization process began.

Under the revised regulations the review of whether the hospitalization was needed was to take place right after the patient got to the hospital. The other requirements that persons other than physicians partake in determining whether the hospitalization was necessary was retained in the revised regulations. They were published finally on Nov. 29, 1974, to go into effect last Feb. 1.

But before the new regulation could take effect, the American Medical Association filed suit in Federal District Court in Chicago, which effectively blocked any new utilization review implementation.

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September with a stipulation between the parties that the Federal agency would draw up new regulations taking into account the objections of the A.M.A.

The A.M.A. set forth a series of basic principles that it felt should limit any new utilization review. Among the limitations were that reviews of admissions should be "limited to those physicians with a demonstrable history of overutilization," that reviews be made only on a sample basis and that "in doubtful cases, great weight shall be given to the judgment of the attending physician."

In light of the A.M.A. objections and the threat of renewed litigation, the Federal regulations were again modified. The Government agency originally had felt that a review before the patient even arrived at the hospital would be the best means of controlling overutilization — on the ground that once a patient was in the hospital utilization, whether necessary or not, already was well under way.

The new rules, which were published in the Federal Register last March 30, said that the review must be completed three working days after the admission.

Critics said this could mean that a patient could have gone through an expensive and possibly dangerous operation before anyone but the admitting physician had confirmed that such an operation was necessary.

To prevent this the newly proposed regulations say that the utilization review must be performed before any elective, or nonemergency, surgery is performed. But the regulations go on to say that "pain, itself, under appropriate circumstances can make an otherwise elective admission into an emergency one."

As in the old proposal, the new one calls for continued stay reviews. That means that if a patient is to stay for a period longer than what is considered normal for his particular condition there would have to be another review before he could be kept longer.

Effective Date Uncertain

The new regulations, however, say that the review would not have to be completed until two days after the date when a patient normally would have been discharged.

The new rules are now being circulated for comments, which are due by June 1. When the new rules will go into effect is still uncertain.

If the new regulations seem