A review of the literature and a survey of Minnesota hospital administrators' attitudes toward change

Suggested Organizational Changes for the Hospital Industry

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THE HEALTH CARE INDUSTRY, deeply capable of affecting the social well-being of the American public is being criticized about its services. This criticism comes from divergent groups and seems to be focused on the steady rise in the cost of health care with no apparent corresponding increase in benefits. A recent publication suggests that the American health system is not in the business for people's health; rather, it is for the power and the profits that can be derived (*1*). Consequently, it seems to consumers that health care costs more while services and benefits are fragmented and minimally available to the average citizen.

When our economy was less affluent, for example, during the Great Depression of the 1930s, the public's priorities for health were not as high as they are today. According to the Social Security Administration (*2*):

> For the 40-year period 1929–1969 medical care expenditures increased from 3.6 billion dollars to 63.8 billion dollars at an annual rate of 7.4 percent. In the latter half of the 1960's, the rate of increase has been about 12 percent—almost two-thirds faster than the long-run rate.

Today, the general public's purse is much more compartmentalized, reflecting our advancing technological and specializing society. The purchasable alternatives are numerous. Where, for what, and how much of available resources will be expended for health care? One indicator of overuse of a particular alternative of health care to the deemphasis of other alternatives has been the upward rate of hospital use during the past 30 years.

The 1946 national program of financing hospital building (Hill-Burton) began on a positive note to upgrade hospital physical structures. This and other financing mechanisms allowed an increase in the number of U.S. hospitals, from 6,125 in 1946 to 7,144 in 1970, with a corresponding increase in available beds (*3*). Because of the increasing tendency of physicians to admit patients for diagnostic tests, a demand was heard for more and more beds and increasingly more expensive diagnostic machinery to be provided in hospitals. Consequently, hospital administrators charged with the responsibility of paying for these items soon discovered that the only way to pay for them was to have more paying patients within the hospital. This trend in medical practice was, and still is to a large extent, reinforced by refusal of most health insurers to pay for other less expensive modes of predictive and outpatient services. These examples are just a few of the many reasons why health care costs are high and continue to accelerate upward.

The behavioral practices of physicians, patients, and hospitals, on the other hand, developed over many years. To expect the health industry and its users to change their behavior rapidly is perhaps foolhardy. But if this is a description of a vicious cycle increasingly escalating, then when, where, and by whom can the cycle be interrupted?

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Hospitals have acquired a central role in the health care delivery system through an evolutionary process. Since they command most of the available health manpower, facilities, and other health resources, hospitals must play a stronger and more responsible leadership role in ameliorating the crisis situation of rising costs and inadequate services. In this pivotal role, the hospital should be a source of leadership in the change process of the health industry and consumer behavior. Innovative change is vitally indicated, and this innovation requires stimulating leadership.

In 1964, Brown (*4*) suggested that hospitals should be community leaders when he called them "obligated enterprises"; hence, the hospital must consider its position in the community as a ". . . very unusual sort of enterprise," which "profoundly affects the public in unusual ways." More recently, Dornblaser, in recommending a solution to the health care dilemma, stressed this same theme of the social responsibility of hospitals (*5*). Such leadership therefore cannot be afraid to upset the practices of the past, nor can it be resistant to experimentation.

The logical choice of many for the leadership role is the chief executive officer of the hospital. Thus, the question arises as to whether today's administrator views himself as an agent for change for the improvement, restructuring, and development of the health care industry toward optimum health benefits for everyone.

Suggested Hospital Industry Changes

In 1959, Brown (*6*) stirred the hospital industry when he advocated the concept of public control of hospitals to enable more effective cost controls. He reasoned that the increasing operating costs and use of hospitals could be controlled only by limiting prepayment rates. He continued that voluntary, effective hospital planning would help preserve the voluntary hospital system and permit the public to retain its freedom of choice. He viewed the threat of government interference as repugnant to the voluntary way of life and to our voluntary system of hospitals. The method of public control acceptable to Brown was that of hospital franchising by a State agency established for that purpose. In his words:

> If there is to be public regulation of the voluntary hospital, State franchising offers the best means of accomplishing the end sought and does the least damage to the values of the voluntary system.

Concerning the rights of individuals versus the rights of society, society has complicated the issue by assuming an aggregate responsibility in certain areas of public interest. In matters of health, it is fundamentally the obligation of the community to protect the health of its members (*7*). However, responsibility for health has been largely a State matter. The States have police power through which they may protect the health of the community, as well as of the individual citizen.

Hospitals are under police power in many ways; two good examples are in the articles of incorporation and the licensure laws of each State. Licensure, however, does not imply new and different organizational structures for the hospital or other components of the health care industry, but it does require compliance with certain minimal standards.

Hospitals can be affected by governmental actions in many ways. The forms of governmental control under which hospitals can come were itemized by Harrison in 1961 (*8*). Although these forms of control are diversified, to date they have been changed only minimally. For example, area-wide health planning agencies established under Public Law 89–749 have been delegated review and concur authority over building programs of hospitals involving Federal funds, but formal delegation of authority has not been standard in the collective States.

Thus, the issue is simply a question of who will control. It seems that the State has the power to influence actions on the part of public interest if it chooses to do so. Rogers (*9*), however, points out that for delegation of control to be effective to meet societal goals, three conditions must be met:

- There must be a clear understanding as to precisely what functions and responsibilities are being delegated and by whom.
- When a function or responsibility is delegated, the necessary authority must also be delegated.
- Broad policy-making and basic control must remain centralized. Nevertheless certain aspects of control can and should be decentralized.

Another view of controls, suggested by Edwards, is that controls of today are due to the difference in growth in formal and informal controls (*10*). Whereas informal controls have been the dominant feature concerning hospitals in the past, Edwards states:

. . . the recent rate of growth of formal controls and their expansion into control of rates, services and financing by indirect administrative decree has been of such magnitude as to challenge the feasibility of informal controls remaining the predominant method.

Edwards contends that informal controls specifically applied to hospitals must be developed to effect the reversal of the growth pattern of formal controls, and that they must (*a*) actually control, (*b*) be of sufficient force and direction to prevent hospitals from adopting devious goals and to emphasize services to society, (*c*) strive to integrate hospitals' goals into society without excessive effort to merely increase acceptance of the status quo, (*d*) be sensitive to and in concert with formal controls, (*e*) be positive and with statesmanship, and (*f*) be established and endorsed by independent, dedicated, and respected representatives of the community (*10*).

After Brown (*6*) contended that voluntary planning was failing, as evidenced by factors such as high cost and increased hospital utilization, and that hospitals should be franchised, McWilliams (*11*) expanded on Brown's ideas by calling for hospitals to be considered as public utilities. Harrison (*8*), in her discussion of controls for hospitals, does not consider this an appropriate label to attach to hospitals, particularly for:

. . . non-profit, charitable organizations, but it is also wholly incompatible with any proprietary hospital (or any non-profit hospital) that does not undertake to serve all members of the public on a non-discriminatory basis.

Harrison also finds that although there are many similarities between the hospital industry and profitmaking public utilities, this is not sufficient cause to fully regulate hospitals and ". . . resort to monopolistic grants of power" (*8*). Current concepts of public interest preclude the notion that some hospitals may discriminate, particularly since the Darling decision of 1965 (*7*).

Mott (*12*) disagrees with Harrison on the applicability of public utility status to hospitals. In Mott's opinion:

Public utility type regulation in the hospital industry would take the same practical approach it appears to have taken in the electrical power industry.
. . . With this type of approach it could take full advantage of voluntary hospital associations and planning agencies, as well as controls within given institutions. It would leave most decision making to the present system, but would impose on the system an agency representing the public interest.

The concept of public utility status is an attempt to systematize and introduce rationalization into the health industry, particularly for hospitals, but it does not clarify what a public utility is and what its characteristics might be. This point has raised many questions as to the applicability of a hospital possibly being identified as a public utility. When an industry or a business enterprise is categorized as a public utility, its major characteristics are (*a*) some form of service franchise as granted by a governmental agency and (*b*) it must serve all customers without discrimination and at reasonable rates (*13*).

Another descriptive phrase used interchangeably with that of franchise is "certificate of public convenience and necessity" (*12*). This means that rather than licensing a hospital after it is built, the State authority is now expanded to issue a certificate of need before it is built (*14*). Proof must therefore be rendered that a hospital is conclusively needed.

New York passed its version of franchising in 1964 (*15*), and since then there has been an issue of who should render the verdict of necessity and where the franchising authority should be located. The New York model suggests that the power be retained in the central State government, while each areawide health planning agency reviews and comments on each proposal for a new hospital or extensive remodeling of older hospitals.

Kralewski (*16*) views the franchising authority as being best located in the State licensing authority and exercised through the areawide health planning agencies. Johnson (*17*) agrees with this, and he views franchising as vital to the prevention of a national system. The alternatives of control and implementation are numerous, but Johnson cites only two: (*a*) a State commission linked to (*b*) areawide health planning agencies. McNerney (*18*) supported the franchising of hospitals in 1970 when he suggested that in the absence of a competitive market a simulated one must be created to control health care costs.

In opposition to the viewpoint that areawide planning agencies should have formal authority to franchise hospitals, Curran (*19*) asks "How can we legally expect them as non-elected bodies to perform public acts without being publicly accountable?" Many such sentiments opposing formal controls have been expressed in emotion-laden questions appearing in the literature. For example, in 1965 a series of three articles appeared in *Medical Economics*. The three authors

of these articles questioned (*a*) whether areawide hospital controls would kill off a particular hospital (*20*), (*b*) how areawide hospital controls would take hold (*21*), and (*c*) how areawide hospital controls would affect the physician (*22*).

At the 1970 Conference on Health Care Costs sponsored by the Minnesota State Planning Agency's Comprehensive Health Planning Program (*23*), the participants concluded that some form of regulatory mechanism to insure implementation of planning and recommendation is a necessity and that areawide agencies should:

> . . . consider some form of "territorial franchise," whereby responsibility for health care in a given area can be established with specified groups and through which they can be held accountable. Broader territorial responsibility for certain specialized services might be established on a regional basis.

Other studies have revealed two sides to the issue of whether or not areawide health planning agencies should indeed have formalized power to enforce plans that they might develop. Hufstedler (*24*) found in his study of Alabama hospital administrators that voluntary planning efforts are more strongly supported than community planning efforts that are enforced by government policy.

Fournier (*25*), in comparing attitudes of planning directors of areawide planning agencies with those of hospital administrators, found that 50 percent of the hospital administrators did not wish to give the areawide health planning agency power to enforce its decisions concerning health care planning, whereas only 19 percent of the planning directors expressed the belief that they should not have this power.

In another study, Wren and associates (*26*) sent a questionnaire to 275 hospital administrators in HEW Region IV of the Southeastern United States to elicit their opinions about comprehensive health planning. They discovered that 76 percent of the hospital administrators considered regional health planning either necessary or absolutely necessary. However, when asked the question, "Ideally speaking, what kind of leadership would you prefer in the field of comprehensive health planning in your State?" 53 percent stated that nongovernmental leadership should be the dominant method. Also, 94 percent of the respondents favored strong involvement of hospital administrators in comprehensive health planning.

Another suggested mechanism for implementation of cost reduction through better management is the "regional health authority." Springall and Durbin (*27*) visualize the regional health authority as an organization that:

> . . . should create administrative mechanisms necessary to maximize efforts in coordination and cooperation. The authority should be designed to combine the prerogative of government with creativity and flexibility of private enterprise.

Wheeler, on the other hand, views the regional health authority as a strong possibility for approaching rural health problems (*28*). A similar alternative in answer to the many questions of how best to deliver and finance health services has been presented by the Ameriplan of the American Hospital Association (*29*). The Ameriplan calls for a health care corporation having control over the resources necessary to provide comprehensive health care to a defined population. This approach is familiar to many people.

The Federal Government has developed the health maintenance organization strategy as a way to better-organized health care institutions and providers that will supply economical health care services to the communities (*30*). This particular strategy not only suggests stronger organizational ties between facilities and physicians, but also stresses disease prevention and health maintenance.

Essentially, these control-related proposals are asking for a management mechanism by which an array of resources can be arranged so as to provide the best health care possible, as economically as possible, for a particular community. The facts today seem to indicate that the traditional organizational structures and controls of hospitals are not meeting contemporary community health needs. Change is needed and will come—the speed at which it will occur and the direction it will take depend on the many variables in the health care system. Among these variables will certainly be the amount of resistance to change offered by the administration of the numerous hospitals in the United States.

Survey of Minnesota Administrators

In 1971, there were 191 licensed hospitals in Minnesota, exclusive of Federal ownership. These hospitals represent all patterns of ownership or control, or both, except profitmaking hospitals, which are not currently in operation in the State. They also include several long-term hospitals owned by the State which primarily provide

psychiatric services. For the purpose of this paper, control refers to the nature of the organization operating the controlling element.

As a part of a larger study, a questionnaire containing seven items was mailed to the chief executive officers of the 191 Minnesota hospitals. In the process of gathering information, it became apparent in reviewing hospital ownership or hospital controls that several Minnesota hospitals are linked together and have the same administrative chief executive officer. Since the study was established to ascertain certain attitudes of the chief executive officer, he or she was defined as "that person who is appointed to the position of chief executive officer either by the respective hospital's governing board or by a higher administrative level." Where two or more hospitals were linked under a common ownership or an umbrella corporation, the chief executive officer of the umbrella corporation was considered the chief executive officer for all member hospitals of that corporation. Under this definition, the original 191 hospitals are under the administrative control of 187 chief executive officers.

Responses to Questionnaire

The number of returned self-administered questionnaires that were usable, as shown in the following table, indicated an extremely high interest of the chief executive officers in participating in the study. Statistical tests showed that those who returned the questionnaire were representative of Minnesota hospitals in terms of size of hospital and ownership.

Questionnaires	*Number*	*Percent*
Mailed	187	100.0
Returned	135	72.1
Unusable	3	1.6
Used	132	70.5

The respondents were asked to check one of five choices following each of the seven statements: strongly agree, agree, indifferent, disagree, or strongly disagree. The statements and the responses to them follow.

1. The chief executive officer of a hospital has the responsibility of providing leadership to his community in matters of planning for its health and health care.

Response	*Number*	*Percent*
Strongly agree	67	50.8
Agree	61	46.2
Indifferent	3	2.3
Disagree	1	0.7
Strongly disagree	0	.0
Total	132	100.0

2. Hospitals should be considered as a public utility.

Response	*Number*	*Percent*
Strongly agree	6	4.6
Agree	37	28.0
Indifferent	18	13.7
Disagree	58	43.9
Strongly disagree	13	9.8
Total	132	100.0

The preceeding data reveal that 53.7 percent of the respondents rejected the concept of the hospital as a public utility and only 32.6 percent endorsed it.

3. As public utilities, hospitals should be so regulated.

Response	*Number*	*Percent*
Strongly agree	1	0.8
Agree	21	15.9
Indifferent	21	15.9
Disagree	69	52.3
Strongly disagree	20	15.1
Total	132	100.0

The number of respondents who disagreed with statement 3 was larger than the number who disagreed with statement 2, as indicated by an increase from 53.7 percent to 67.4 percent. This increase is probably related to the fear of introduction of severe regulations or external controls applied to hospitals. Apparently it is easier to accept hospitals as public utilities in name only. When it comes to control and regulatory mechanisms which might interfere with the prerogatives of the individual chief executive officer, he decides that external controls should not apply to hospitals.

4. Franchising of hospitals is essential to maintain order in the hospital industry.

Response	*Number*	*Percent*
Strongly agree	9	6.8
Agree	34	25.8
Indifferent	24	18.2
Disagree	52	39.4
Strongly disagree	13	9.8
Total	132	100.0

Obviously, the respondents were rather ambivalent to statement 4, and it is difficult to draw any inferences except in relationship to statement 3. As I indicated earlier, franchising is one form of control of public utilities, but it has also become more popular among private enterprises. Thus,

although contradictory, the data might be considered consistent with today's business attitudes. On the other hand, it seems that the responses are far more compatible with those given to statement 2 than to statement 3.

5. Hospitals should be required to possess a "certificate of need" prior to the expansion of any service or facility.

Response	*Number*	*Percent*
Strongly agree	31	23.4
Agree	73	55.3
Indifferent	6	4.6
Disagree	16	12.1
Strongly disagree	6	4.6
Total	132	100.0

The responses to statement 5 revealed that 78.7 percent of the administrators favored the certificate of need. This percentage is in contrast to the responses to statement 4 that indicated ambivalence to franchising, but it is a much larger figure than the percentage of administrators who disfavored regulation of hospitals as a public utility. To the majority of the respondents, public utility seems to mean the meeting of certain minimal requirements, as well as developing programs if so required by the public. The certificate of need requirement, however, does not possess this type of regulatory mechanism within its framework. It does nothing more than require that the certificate be issued or that public need be demonstrated before new facilities are built or programs are implemented.

6. An areawide comprehensive health planning agency should possess formal authority to enforce those plans which it develops.

Response	*Number*	*Percent*
Strongly agree	15	11.4
Agree	74	56.1
Indifferent	15	11.4
Disagree	25	18.9
Strongly disagree	3	2.2
Total	132	100.0

Areawide health planning agencies must have formal control mechanisms at their disposal to make planning work within whatever framework they are using. The responses to statement 6 compare favorably with those to statement 5. Generally, the chief executives were more in agreement with this concept than not; this may be true because of the increased publicity of areawide health planning or, more simply, an awareness of the planning agencies' lack of formal controls.

7. All health care services and facilities should come under the umbrella of some larger organization, as for example, an area health care corporation.

Response	*Number*	*Percent*
Strongly agree	2	1.5
Agree	43	32.6
Indifferent	18	13.6
Disagree	57	43.2
Strongly disagree	12	9.1
Total	132	100.0

Although the concept of a health care corporation for a particular area or population is not new, it is now receiving more attention. Many of the administrators did not favor such a corporation; their responses were similar to those for the public utility concept. This response may simply mean that the respondents see an umbrella corporation as depriving them of the prerogatives of independent management of a single unit within the loosely knit health care system of today.

Conclusion

The chief executive officers of the Minnesota hospitals generally have agreed that they should be involved in community health planning and also that a hospital should not be considered as a public utility nor regulated as one. They also agreed that franchising is not necessary to maintain order in the hospital industry, and that all health care services and facilities should not come under some larger organization, for example, a health care corporation. On the other hand, they generally agreed that hospitals should be required to possess a "certificate of need" before the expansion of any service or facility, and that areawide comprehensive health planning agencies should have formal authority to enforce the plans that they develop. Interestingly, the 1971 Minnesota Legislature passed, and the Governor subsequently signed, a certificate of need law authorizing the areawide planning agencies to have formal review and concur authority and to approve the issuance or nonissuance of certificates of need to hospitals and health-related institutions.

The concept of planned developmental change within the health care industry, particularly when applied to hospitals, suggests that some solution for introducing control into the health care industry might be considered threatening to the role of the hospital chief executive officer, particularly in Minnesota. The underlying theme of all the suggestions for further systemization and reorganization of the hospital industry stresses that external

controls are forthcoming; most of these suggestions were rejected by the Minnesota chief executive officers.

The study respondents, however, did not reject the concept of areawide comprehensive health planning agencies having further controls to implement and develop plans. Apparently such agencies do not constitute as large a threat as the other suggested plan changes illustrated in the other statements. Possibly, too, the chief executive officers of the Minnesota hospitals were reflecting on the situation at the time when comprehensive health planning agencies do exist but do not have extensive formal power. It might also be true that the Minnesota hospital chief executive officers believe they can control the dictates of the comprehensive health planning agencies, whereas they could not control organizations at other governmental levels.

The concept of certificate of need is apparently less threatening as a control measure because it implies an informal form of control by the hospital rather than an external force. Finally, the responses to the questionnaire clearly indicate that Minnesota hospital chief executive officers can accept involvement in a planning society, but are most resistant to an externally planned society.

REFERENCES

(1) Ehrenreich, B., and Ehrenreich, J.: The American health empire: power, profits, and politics. Vintage Books, New York, 1970.

(2) Cooper, B. S., and McGee, M.: National health expenditures fiscal years 1929–70 and calendar years 1929–69. Research and Statistics Note No. 25, Dec. 14, 1970. Office of Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare, Washington, D.C.

(3) American Hospital Association: Table 1. Trends in utilization, personnel, and finances for selected years 1946–69. Guide issue, Pt. 2. Hospitals 44: 472–474, Aug. 1, 1970.

(4) Brown, R. E.: The hospital as an obligated enterprise. Trustee 17: 1–8 (1964).

(5) Dornblaser, B. M.: The social responsibility of general hospitals. Hosp Adm 14: 6–17, spring 1969.

(6) Brown, R. E.: Let the public control utilization through planning. Hospitals 33: 34–39, 108–110, Dec. 1, 1959.

(7) Shain, M., and Roemer, M. I.: Hospitals and the public interest. Public Health Rep 76: 401–410, May 1961.

(8) Harrison, G.: Government controls and the voluntary nonprofit hospital. American Hospital Association, Chicago, 1961.

(9) Rogers, E. S.: Delegation and control in government-hospital relationships. Hosp Adm 8: 18–29, summer 1963.

(10) Edwards, S. A.: The contemporary hospital and social control. Hosp Adm 10: 95–121, fall 1964.

(11) McWilliams, W. J.: Make hospitals public utilities. Hospitals 34: 44, 47, 48, Oct. 1, 1960.

(12) Mott, A. T.: The applicability of public utility type regulation to the hospital system. Master's thesis. University of Michigan, Ann Arbor, 1966.

(13) New York Chamber of Commerce: Public regulation of utility enterprise. New York, 1960.

(14) Glasser, M. A.: Planning for hospital and extended care facilities—issues of public policy. Am J Public Health 57: 1728–1734, October 1967.

(15) Somers, A. R.: Hospital regulations: The dilemma of public policy. Princeton University Press, Princeton, N.J., 1969.

(16) Kralewski, J. E.: Franchising hospitals as a control mechanism. Hosp Forum 12: 12–14, 22, 24, spring 1969.

(17) Johnson, E. A.: Is franchising necessary? Hospitals 42: 50–52, 114, Mar. 16, 1968.

(18) Hospital franchising asked. Heartbeat 8: 4, May 1970.

(19) Curran, W. J.: Comprehensive health planning: audacious law making. Am J Public Health 58: 1100–1101, June 1968.

(20) Smith, C.: Areawide hospital controls: Will they kill off this hospital? Med Econ 42: 108–121, May 17, 1965.

(21) Corlova, J.: Areawide hospital controls: How they're taking hold. Med Econ 42: 122–138, May 17, 1965.

(22) Smith, M.: Areawide hospital controls: How they'll affect you. Med Econ 42: 142–171, May 17, 1965.

(23) Minnesota State Planning Agency, Comprehensive Health Planning Program: Summary: Conference on Health Care Costs. The Program, St. Paul, Jan. 30, 1970.

(24) Hufstedler, J. E.: A survey of Alabama hospital administrators' attitudes toward compulsory regional health planning. Master's thesis. University of Alabama, Tuscaloosa, 1968.

(25) Fournier, G. E.: A study of the attitudes of New Jersey hospital administrators and planning agency executive directors toward regional health care planning and the medical care of individual patients. Master's thesis. University of Minnesota, Minneapolis, 1969.

(26) Wren, G. R., Benuch, L., Broch, A., and Greene, W.: What do administrators think about health planning? Hosp Top 48: 24–26, December 1970.

(27) Springall, W. H., and Durbin, R. L.: Regional health authority: structure for coordinating resources, services. Hosp Top 46: 33–37, April 1968.

(28) Wheeler, K. E.: The regional health authority: A possible approach to rural health problems. Inquiry 7: 15–31, June 1970.

(29) American Hospital Association: Ameriplan: A proposal for the delivery and financing of health services in the United States. Chicago, 1970.

(30) Cavanaugh, J. H.: Proposed HMO programs can improve system. Hosp Prog 52: 26–29, 44, January 1971.