Impact of Government Programs on Voluntary Hospitals

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A LONG CONCERN in American life has been to extend health services to the population through organized measures, while not stifling individual initiative and responsibility. This concern is now particularly directed to the potential influence of government on our voluntary hospital system. Fear is expressed that various financial innovations may lead to governmental domination or even the complete governmental control of hospitals.

This is, of course, not the first time that the phenomenon of governmental participation in the provision or the financing of health services has been greeted with apprehension. Voluntary initiative is naturally cherished in America, and encroachments on it, even if they are only potential, have long been resisted. Yet over the years the role of government in health service has steadily expanded. New public programs have evolved at all levels: local, State, and Federal. And these programs have involved a widening scope of technical activities in medical care in general and hospital service in particular.

It is not necessary, therefore, to speculate unduly on the influences of government on voluntary social institutions. A vast experience exists and can be studied. Specifically, it is quite possible to determine the actual impact of governmental programs on voluntary hospitals in the United States. This paper reports the preliminary findings of such an investigation.

Our first task was to identify and define the principal governmental programs now impinging on voluntary hospitals. These are found operating at all political levels and may be conveniently classified as programs which support specified beneficiaries, provide general financial assistance, or have regulatory authority. We are not considering governmental provision of hospital service per se, an expanding practice also, but rather only governmental impacts on existing voluntary hospitals. The principal governmental programs whose impacts were to be explored were classified as follows:

Support of Specified Beneficiaries

Federal

Veterans "hometown" care.
Military dependents ("Medicare").
Members of the armed services on leave.
American Indians.
Federal employees with compensable injuries.
Other Federal beneficiaries.

State

Public assistance "categorical" recipients (old-age assistance, dependent children, blind, or totally and permanently disabled).
Injured workers (workmen's compensation).
Patients with cancer or other specific conditions (in certain States), excluding mental illness and tuberculosis.
Vocational rehabilitation clients.
Other State beneficiaries.

Local

General assistance recipients.
Other local government beneficiaries.

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Provision of General Financial Assistance

Federal

Hospital construction grants (Hill-Burton law).
Research grants.
Federal tax exemptions.
Other Federal assistance.

State

Hospital construction grants (certain States).
Research grants.
Laboratory or X-ray services.
Commodities (drugs, food, and so on).
State tax exemptions.
Other State assistance.

Local

General financial grants, such as "deficit" subsidy.
City or county tax exemptions.
Other local government assistance.

Regulatory Programs

Federal

Narcotics and alcohol control.
Federal trade and labor legislation.
Other Federal regulations.

State

Hospital licensure or approval law.
Supervision of nursing education.
Labor legislation (protection of women and children, and so on).
Other State regulations.

Local

Public health or sanitary regulations.
Fire prevention code.
Other local regulations.

Thus, there are some 30 clearly definable governmental health programs, and several "others" which may be found in different places, now operating in an average community. All or most of these may be expected to have a variety of impacts on voluntary hospitals. The problem is complicated by the fact that for nearly every program a different Federal, State, or local public agency is involved. From the research point of view, however, this widens the sample of "influences" and permits more reliable generalizations.

The nature of these governmental impacts on hospitals is not so easy to define, let alone to measure. Objective effects may be quite different from subjective perceptions. As a first approach, however, we felt that some insight could be gained by tapping the impressions of hospital administrators on the effects of these specific programs. Thus, we set out to examine the "observed" impacts of governmental programs on voluntary hospitals, which hopefully correspond closely but not necessarily exactly to the objective impacts of these programs.

For each program listed, the potential impact was to be examined in terms of one or more of five aspects. These concerned the program's influence on patient care, motivation of the hospital staff, administrative practices, financial support, and development of services and facilities. A schedule was constructed to elicit impressions of hospital administrators on all or some of the potential consequences that might be anticipated from each of the specific programs. The first draft of this schedule was pretested by interviewing six hospital administrators from six different States, who were available at a summer postgraduate institute. After revision on the basis of this testing, the schedule was applied, by direct interview of the administrators, in 10 hospitals of upstate New York. The final study will cover about 100 hospitals in several States. These interviews, carried out on the spot in each hospital, were done with care, requiring 3 to 8 hours each. In six places they were supplemented by interviews with other members of the hospital staff for data on specific points.

Findings

The 10 institutions in which governmental impacts were examined were all general hospitals under voluntary nonprofit auspices. Two were Catholic, the others nonsectarian. They ranged from 52- to 450-bed capacity, with an average size of 218 beds. All were well established in their communities, the newest being 34 years old and the oldest 108 years. No claim is made as to the representativeness of this sample; it was selected mainly by proximity of the hospitals to Cornell University, but with an effort to cover a range of sizes and to include several which had received Federal construction grants. The findings, however, on the observed impacts of current governmental programs on voluntary hospitals provide several clues which may be later explored in a larger sample of institutions. The effects of each type of governmental program, in the judgment of the

hospital administrator, will be considered according to the general categories cited.

Specified Beneficiaries

All 10 voluntary general hospitals served one or more of the several categories of health beneficiaries of the Federal Government. The volume of such cases in all instances, however, was small. The recent trend, moreover (within the last 10 years), has been toward a stationary level or a decrease in the percentage of total hospital income derived from this source. It was for this reason perhaps that the administrators stated that the several programs for Federal beneficiaries had only a negligible influence on overall hospital operations, including utilization, financing, patient care, or other possible consequences.

In response to a specific question on whether these Federal funds for specified beneficiaries "have caused the Government to exercise control over your operation or management," all 10 administrators responded "no control." The same uniform response followed a question on whether the Federal program had "caused, either directly or indirectly, the board in your hospital to change its policies and programs." Furthermore, all reported "cooperation between the hospital staff and Government officials administering Federal medical care programs" to be "good" or "very good." None reported relationships as "fair," "poor," or "very poor." These uniformly favorable reports are perhaps all the more remarkable in view of the fact that four or five separate Federal agencies are involved in the administration of these programs.

All 10 hospitals reported service to one or more groups of specified beneficiaries of the New York State government. The relative volume of cases, again, was small; those who could estimate its financial impact on the hospital believed it to be under 1 percent of the total income. Mentally ill and tuberculosis patients were not considered in this report since they are customarily cared for in State-operated hospitals. The patients usually recognized as beneficiaries came under the vocational rehabilitation, crippled children's, or workmen's compensation programs, involving three separate State agencies. Statewide data show that payments for workmen's compensation cases constitute about 2.5 percent of hospital income, an impact obscured by the fact that, although workmen's compensation is a governmental program, payments are made by different insurance companies. In New York State, public assistance beneficiaries are not handled by the State but by local units of government. A few administrators stated that the funds received for these beneficiaries had been of some help to the hospital in developing rehabilitation services. In all instances, relationships with State government officials were said to be "good" or "very good."

Specified beneficiaries of local governments were also served by all 10 hospitals. Indeed, since local governments in New York State are responsible for all categories of public assistance recipients, the estimated volume of care provided this group by the local government was greater than that provided for beneficiaries of Federal and State Governments. However, it should be kept in mind that the funds for financing medical care of these needy persons are derived from the Federal and State, as well as local, governments, even though the payment of hospital and medical bills is a function of county welfare departments. As a portion of hospital income, funds paid by local government for its beneficiaries were estimated to vary between about 1 percent and 11 percent, with half of the administrators stating 5 percent or more.

With this larger relative volume of beneficiaries coming under local government administration, it is not surprising that the observed effects of government participation in health services were greater for local than for Federal and State Governments. Half of the 10 administrators stated that these local government funds had enabled them to give better care to patients. Comments were made on the effect of these programs in helping to finance better equipment, improved child health services, rehabilitation, and outpatient department services, or in maintaining higher utilization of the institution. One hospital, incidentally, was reported to have kept its bed complement above a certain threshold level, in order to be entitled to a higher reimbursement rate for the care of local government beneficiaries. Greater impacts on a hospital were associated with higher

percentages of income derived from local governmental sources.

In contrast to health services for State and Federal beneficiaries, administration of programs for beneficiaries of local governments drew some criticism. Two hospital administrators expressed the belief that the program exercised some control over the operation of the hospital. One of these expressed fears about the future extension of governmental supervision over the care of the indigent, although current "controls" were deemed to be reasonable. No specific question was put to the administrators on the adequacy of local governmental payment rates, but in response to an invitation for "other comments" four volunteered that the rates were inadequate. One of these remarked specifically about the exclusion of expenses for teaching and research in computing hospital per diem costs. In this connection, it should be kept in mind that payment rates to hospitals by local welfare agencies for the care of needy persons are determined in part by the New York State Department of Social Welfare. In one instance, there was a complaint about the payment rate for hospital care by a Federal program, that for military dependents. As for relationships with local government officials, seven hospitals reported them to be "good" or "very good," but three stated that they were only "fair."

It is evident that among the three levels of government responsible for supporting hospital services for designated beneficiaries, negative reactions of hospital administrators seemed to be concentrated on local agencies. Even here, however, the majority of the hospital administrators interrogated appeared to evaluate the impact of the governmental program favorably.

General Financial Assistance

Federal, State, and local governments all provide varied forms of general financial assistance, not tied to specific beneficiaries. At the Federal level, best known is the Hill-Burton program providing grants to the States for helping to meet hospital construction costs. Five hospitals in the study had received such aid. The administrators of all five stated that these grants had not led to any governmental control over hospital operation, but one thought the construction standards applied were "excessively demanding." The only comment on "controls" over hospital operation by the Federal Government was made by one administrator regarding supervision over the use of radioactive substances; this is exercised by the Atomic Energy Commission and was deemed to be reasonable. Four administrators of hospitals receiving construction grants believed their hospitals had been aided in providing improved patient care.

Federal research grants had been received by two hospitals. These administrators thought the requirements for receipt of this assistance were reasonable or "nonexistent." These grants were said to add prestige to the hospital, thus facilitating recruitment of staff, and to improve the care of certain patients. However, one administrator mentioned space problems caused by the research work.

Other forms of Federal assistance come to hospitals through certain benefits in kind. Nine hospitals had received surplus food from the U.S. Department of Agriculture, according to a formula based on the number of welfare beneficiaries served per month. Seven had received durable surplus property, including autoclaves, incubators, and office equipment, through the New York State Department of Education. The reaction to this type of assistance was generally favorable because of the financial savings.

The State government provides general financial assistance to hospitals in the form of free laboratory services. Four of the 10 voluntary general hospitals in the study reported such aid through the privilege of having serologic tests and various bacteriological examinations done without charge by a State public health laboratory. It is probable that more than these four hospitals avail themselves of such State services.

A variety of other forms of assistance from the State government was reported by several hospitals. These included free drugs, such as silver nitrate for instilling in the eyes of newborn infants and poliomyelitis vaccine for immunizing hospital employees. Two hospitals mentioned support for routine chest X-rays

on all admissions, through a New York State Department of Health award of $1 per film. Other benefits mentioned were the training of a hospital laboratory technician in a State laboratory, with governmental assumption of the technician's salary during the training period, provision of teaching material for a prenatal class, the services of a heart specialist at periodic cardiac clinics, and epidemiological consultation on a problem in the nursery for the newborn. One hospital, which serves as a teaching center for a New York State-operated medical school, receives a substantial subsidy from the school; its agreement with the State government calls for a grant to meet the annual deficit, after an official audit. In 1958, for example, this amounted to $240,000.

All of these forms of general financial assistance from the State government, direct or indirect, were regarded favorably by the hospital administrators, and were not associated with excessive administrative demands.

At the local government level, none of the 10 administrators reported aid in meeting construction costs, balancing of deficits, acquisition of real property, or the like. Three hospitals reported that free diagnostic tests were performed for the hospital by a county or city governmental laboratory; another hospital performed laboratory services for the county health department, for which payment was received. Two hospitals enjoyed savings on their water bill, through special action of the local government.

One other form of indirect financial support is provided to all voluntary nonprofit general hospitals by all levels of government. This is exemption from certain taxes which must be paid by other economic enterprises. The administrators were queried on the procedural requirements for receiving these tax exemptions. All 10 thought the Federal and State Government requirements reasonable for granting the exemptions. In addition, five hospital administrators cited exemption of tax payments on alcohol as offering significant savings; one of these mentioned a saving of $19,000 in the previous year.

Exemption from local property taxes was reported by nine hospitals. The 10th institution is associated with a private medical clinic and pays $8,000 a year in local taxes. Of the nine hospitals, six administrators said the local tax exemption was a substantial benefit, two a moderate benefit, and one thought it inconsequential.

Regulatory Functions

Unrelated to any program of financial support, Federal, State, and local governments exercise certain regulatory authority over voluntary hospitals. The statutory authorities for these regulations differ widely, but all are designed to protect the public interest. The most widely applicable Federal regulation affecting hospitals is the narcotics control program of the Treasury Department. All 10 hospital administrators were familiar with this authority, and 9 thought it was reasonable. The 10th was critical only because he believed that the scope of the controls was not broad enough; he thought they ought to be extended to cover all hypnotic drugs, as well as the legally defined narcotics.

As implied by the restricted Federal authority specified in the United States Constitution, regulatory functions are exercised most extensively at the State government level. Voluntary general hospitals come under the supervision of several separate State agencies, with respect to different matters.

In contrast to most other States, overall certification and approval of hospitals in New York is a responsibility of the State department of social welfare, and all 10 administrators had had some experience with this authority. The frequencies of official inspections recalled by the administrators, however, varied greatly. Two stated the last inspection had been made 6 years ago, one estimated the frequency of inspections as "every 5 years," two as "every 3 years," two as "every 2 or 3 years," and the remaining three as "less than annual" or "don't know." As the apparent irregularity of these visits might suggest, the estimated impact of this regulatory program was uneven. Three administrators thought the inspections were inadequate and made no particular difference to the hospital. Two thought the inspectional authority "excessive," but still exerting "no effect" on the administration of the hospital. Two others thought the program

"about right" in its scope, yet having "no effect" on the hospital. On the other hand, three administrators thought the inspectional authority to be proper and to have stimulated improvements in the operation of the hospital. One of these explained that the social welfare department inspections and recommendations gave the administrator "leverage" with the board of directors in initiating needed changes in the hospital.

Despite the irregularity of on-the-spot inspections by State authorities, all hospitals must send financial reports annually to the State welfare department. No objections were raised to this requirement, which serves as a basis for computing maximum reimbursement rates, shared by the State government, for the care of public assistance beneficiaries. Reports are also required of any new construction at a hospital, and architectural plans must be approved by the State welfare department regardless of the source of financing, that is, independent of approval of construction under the Federal Hill-Burton program. This requirement was criticized by two administrators, who thought it was unnecessarily time consuming and unreasonable. They questioned how review of construction plans by a nurse could be justified.

In New York State, inspection and approval of nurseries for the newborn is a function of the State department of health. While overall hospital approval has long been a welfare department responsibility, a number of tragic epidemics of diarrhea among infants in hospital nurseries some years ago led to the assignment of special authorities in this field to the public health agency. The standards applied in this regulatory field are apparently somewhat rigid, and comments on them by the administrators were more voluble than on any other type of regulation. Three administrators complained that the nursery regulations caused additional expenses and much extra work. There was dissatisfaction with the requirement that nursing personnel could not be transferred from the maternity service to other sections of the hospital, even in periods when occupancy in the maternity ward was low. These administrators felt that this requirement caused inefficient use of expensive manpower. Yet they all conceded that these regulations had stimulated improvement in the quality of care of the newborn. One administrator was seeking financial support from the State government for the operation of a unit for premature babies.

Supervision of schools of nursing comes under the State department of education. Four of the 10 hospitals studied conducted such schools, and the directors of these nursing schools were interviewed. All four thought the educational regulations were reasonable and helpful and gave the schools adequate leeway in running their own affairs. One director, however, expressed the view that the department of education overemphasized the academic, as against the practical, aspects of the nursing school program.

A variety of other State government regulations were mentioned by the hospital administrators, but none with any rancor. The legal supervision by the New York State Department of Labor on employment of minors was deemed reasonable, as was the safety inspection of water boilers and elevators. Two administrators even expressed the opinion that State requirements on fire prevention and sanitation might desirably be imposed in communities where local regulations in these fields were weak or lacking. Occasional inspections under the food and drug control laws of the State were mentioned, without objection. One administrator did make reference to the professional licensure acts for nurses and pharmacists, with the comment that they tended to restrict hospitals unduly in the engagement of such personnel.

Turning to regulatory functions under local government, all 10 hospital administrators had noted the operation of local regulations in the field of environmental sanitation. This authority, exercised by the local health department or health officer, was deemed reasonable by eight administrators. The criticisms by the other two, indeed, were that the standards applied were inadequate or that enforcement was too weak.

Fire prevention regulations were recognized by nine administrators, without any negative reactions. As an example of the concrete effects of these regulations, one administrator reported the recent installation of new fire protective equipment. Local regulations on the control of air pollution (furnace operation)

were criticized by two administrators as excessively demanding.

Competition by Government

A final aspect of governmental impacts on voluntary general hospitals, which had not been anticipated in the original research design, emerged from the interviews with administrators. This was the role of government as a "competing" organization through its operation of public hospitals. We did not examine this effect in detail, but certain findings appeared.

Apparently due to their location in a large city, where a Federal Veterans Administration hospital exists, two hospital administrators reported a double influence of government on voluntary hospitals. First, they stated, the Federal hospital "took patients away" from them; if a veteran was legally entitled to free care in a governmental facility, why should he pay for it in a voluntary unit? Second, the personnel policies of the VA hospital, especially the wage rates, put the voluntary hospitals under pressure to offer competing conditions in order to recruit staff. While the two administrators could not really condemn these competitive forces, they said their jobs were thereby made harder.

A similar competitive influence of State government was reported by one administrator, whose hospital was close to a specialized rehabilitation center operated by the State department of health. This publicly financed center naturally attracted handicapped patients who might otherwise have gone to the voluntary hospital. Competitive influences of local government were not reported.

Comment and Conclusions

This report of a pilot study of governmental impacts on voluntary hospitals must be taken for what it is, preliminary rather than conclusive. Even so, certain impressions and suggestive ideas emerge.

First of all, it is clear that a great variety of governmental programs are now in operation and are exerting numerous influences on the Nation's voluntary general hospitals. The programs emanate from all political levels—Federal, State, and local—and involve support for specified beneficiaries, general financial assistance, public regulation, and competitive services.

Second, the overall influence of these programs on the operation of voluntary hospitals is judged by administrators as neutral or beneficial. Negative criticisms are in the minority. Relationships between the hospitals and governmental administrative authorities are, on the whole, good; there seems to be very little evidence of any sense of domination by government.

Third, the quantitative impact of government on the hospital's operation and development appears to be greatest for programs giving general financial assistance, next for programs supporting specified beneficiaries, and least for regulatory programs. The specific beneficiary programs, on the other hand, should perhaps be judged more by their impact on individual patients than on hospital administration per se. The regulatory programs are criticized as often for their weaknesses as for their strengths; their impact is evidently greatly reduced by voluntary standard setting or "accreditation" programs in the same field. One must even suspect that in many, if not all, programs, governmental agencies have leaned over backwards to keep their requirements minimal, even though their mission is manifestly to protect the public welfare.

Fourth, unlike common assumption, the extent of "controls," at least those recognized as restrictive or objectionable, is not related to the extent of money granting authority. The agency that pays the piper is apparently felt to be calling the tune more gently than the one that doesn't. While the overall reaction of hospital administrators, even to regulatory programs, is neutral or slightly favorable, there are more criticisms of the exercise of these authorities than of those associated with grants of money.

Fifth, another common assumption was shaken by the finding of a generally more favorable attitude toward programs emanating from the Federal Government than from State or local authorities. Reactions to all governmental programs were predominantly favorable, but the strongest criticisms related to local government.

Sixth, it appears that administrators of voluntary general hospitals are, on the whole, living contentedly with a great variety of governmental programs, not regarding them as particularly disturbing in one direction or another. There were, indeed, some apprehensions expressed about government, but they nearly always referred to some suspected future, rather than to current or past experiences. In a sense, the overall equanimity of responses was the most significant finding of this pilot study; the minority of negative responses often emerged from second questions rather than coming spontaneously. This is all the more interesting in view of the conduct of this pilot study among voluntary hospitals in upstate New York, a region long known for its conservative attitudes toward government, in general.

Finally, reading between the lines of the responses to the structured interviews, one detects much inadequate understanding of governmental programs and authorities by some administrators. The rules of the game are sometimes not clear, and one suspects that an occasional impression of governmental rigidity comes from a philosophical mind set, rather than from a positive knowledge of governmental policies. On the other hand, with the great number and the changing character of governmental agencies and programs, it is small wonder that hospital administrators are sometimes not fully informed on all the details. It is trite, perhaps, to point out a need for coordination and streamlining of governmental programs.

These comments must be offered more as impressions than as definitive conclusions. Doubtless they are contrary to the impressions of some persons, although much that is said about the influence of government on voluntary institutions in American life is manifestly based on an a priori ideology and anxiety about the future, rather than on objective observation today. Whether a great extension of governmental impacts on voluntary hospitals in the future would alter the evaluations of administrators is another matter, but it would seem that actual experience has greater prognostic value than speculation. It is our hope to pursue this question with a larger sample of voluntary general hospitals, in various parts of the United States. It is hoped also to explore the impacts of government beyond their perceptions by administrators and down to their measurable consequences in actual hospital operation.

American-Soviet Meeting on Poliomyelitis

A mission selected by the Public Health Service represented the United States at an American-Soviet meeting on poliomyelitis in the Soviet Union May 12 to 16, 1960. The first under the U.S.-U.S.S.R. exchange agreement of November 1959, the mission followed the invitation of the Minister of Health of the U.S.S.R. A similar joint meeting in the United States is scheduled for 1961.

Dr. David E. Price, Assistant Surgeon General of the Public Health Service was personal representative of the Surgeon General and chairman of the United States delegation. Among the members were Dr. Roderick Murray, of the Service's National Institutes of Health; Dr. Alexander Langmuir, of the Public Health Service's Communicable Disease Center, Atlanta, Ga.; and Dr. Albert Sabin of Children's Hospital, Research Foundation, Cincinnati, who developed the live poliovirus vaccine now widely used in the Soviet Union. The following topics were discussed:

- Evaluation of the results obtained in mass immunization of the population with live poliomyelitis vaccine from the Sabin strain.
- Report on American activities with reference to live poliovirus vaccine.
- Evaluation of quality control methods for live poliovirus vaccine.
- A program for joint Soviet-American studies on poliomyelitis.