



The American  
Hospital

What Does the  
Future  
Hold?

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C O N F E R E N C E R E P O R T

# The American Hospital

## What Does the Future Hold?

**H**ealth policy makers, economists and other experts on the hospital industry gathered in the Rotunda of the Ronald Reagan Building and International Trade Center in Washington, D.C., on April 21, 2003, to ponder the future of the American hospital. The conference, almost two years in the planning, was sponsored by the Federation of American Hospitals, the Council on Health Care Economics and Policy, the Center for Studying Health System Change, Health Affairs, the California Healthcare Association, GE Medical Systems, CIGNA, and Johnson & Johnson. A videocast and transcript are available on Kaiser Family Foundation's [www.kaisernetwork.org](http://www.kaisernetwork.org). Papers presented at the conference will appear in the fall, 2003 edition of the policy journal *Health Affairs*. This report summarizes the main themes and forecasts voiced at the conference.

# THE AMERICAN HOSPITAL: WHAT DOES THE FUTURE HOLD?

By *Christopher Connell*

WASHINGTON

**T**he nation's 4,800 community hospitals occupy a unique place in American life. Despite constant challenges and changes, they remain the hub of the U.S. health care system, the institution people turn to when their medical needs are the greatest. Momentous events are routine occurrences in hospitals, from the nursery and recovery room to the emergency department and surgical suite. Hospitals are complex and costly enterprises whose own operations have been put to severe tests in the decade past. With the ascendancy of managed care and the surge in outpatient services, hospital stays became ever shorter. Hospitals found themselves competing with ambulatory surgical centers and “niche” hospitals often owned by the same physicians they looked to for patients. The government squeezed Medicare payments and made hospitals the focus of fraud and abuse probes. It decreed that emergency care must be provided regardless of patients' ability to pay, and imposed unfunded mandates to bill claims electronically and erect new privacy safeguards. In the past two decades hospitals' share of the health dollar shrank from 42 cents to 32 cents; margins have grown perilously thin, and shortages of nurses, pharmacists and other staff now are common. What will the next decade be like for the American hospital?

In a capital often preoccupied with short-term consequences, the Federation of American Hospitals, the Council on Health Care Economics and Policy, the Center for Studying Health System Change and several organizations convened a symposium April 21 where academic, business and medical minds were invited to peer out on that horizon.

As Charles N. Kahn III, president of the Federation of American Hospitals, noted at the outset, “It is difficult if not impossible to look into the future and call it right other than by luck. However, it is possible to look into the future and make wise judgments about the direction one should go.” Stuart H. Altman, chair of the Council on Health Care Economics and Policy, said, “The hospital is an important component—many would say it's the most important component—of our health system, and it's had a bit of a rocky past and probably will have a rocky future in terms of what its structure looks like.” Altman, the Sol C. Chaikin Professor of National Health Policy at Brandeis University who was chairman of the Prospective Payment Assessment Commission for twelve years, said the aim was to take a long view of hospitals' future, rather than being consumed by immediate questions such as “whether the DRG payment ought to go up by 0.25 or 0.72

percent” or how to mitigate the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–91).

The day-long symposium capped a nearly two-year process in which Kahn, Altman and other experts including Uwe E. Reinhardt of Princeton University, Gail Wilensky of Project Hope and Paul B. Ginsburg of the Center for Studying Health System Change grappled with these questions themselves. The sponsoring organizations held focus groups of health care specialists in Boston, Washington, Minneapolis, Little Rock and southern California then commissioned papers that became the framework for the symposium. (*Editor's note: a complete list of the members of the experts who comprised the conference's planning committee appears at the end of this report.*)

What will the demand be for hospital services over the next 10 years? Will hospitals be able to meet these demands, both in terms of physical capacity and personnel? Will they have access to the capital necessary to build new facilities and remodel old ones for a growing, aging population? What will the role of the hospital be in delivering new technology and medical advances to patients? Will it be bolstered or bypassed by advances in bioengineered medicines? Will hospitals find ways to repair fractured relations with medical staffs and, more importantly, deliver on the long promised but seldom achieved promise of integrated medical care? Will they be strengthened or undermined by the consumer movement and efforts to shine light on hospital quality and mistakes? And finally, what is the payment outlook, and will hospitals be swamped by growing numbers of the uninsured?

The audience for this wide-ranging conference included representatives of key congressional committees and federal agencies that administer Medicare and Medicaid and set health policy. The report that follows offers a detailed look at the forecasts offered by the ten presenters who spoke at the conference. Following the format of the symposium, it is divided into six sections:

## **I. Is The Past Prologue?**

## **II. Future Demand: Demographics and Patient Care**

## **III. Future Supply: Capital, Technology, and Workforce**

## **IV. Integrated Medical Care**

## **V. Patients/Consumers as the New Third Party in Health Care**

## **VI. Who Pays for Hospital Care and How?**

This report ends, as the conference did, with a brief summary by Stuart Altman on lessons learned.

## I. IS THE PAST PROLOGUE?

**Presenter:** *Jeff Goldsmith, President, Health Futures, Inc. and Associate Professor of Medical Education, School of Medicine, The University of Virginia*

**Moderator:** *Charles N. Kahn III, President, Federation of American Hospitals*

**J**eff Goldsmith, Ph.D., established his credentials as a prognosticator of health industry trends with an article in the *Harvard Business Review* in 1980 that posed the question, “Can Hospitals Survive?” In that article and a book of the same title published the following year, Goldsmith, then director of planning at the University of Chicago Medical Center, bluntly warned that hospitals were threatened by the rise of ambulatory care and outpatient procedures, by the growth of home health care and other services outside the hospital setting, and by increased enrollment in managed care. He warned that hospitals faced growing competition from physicians for services they could perform in their own offices or facilities at lower cost, and correctly predicted a sharp decline in inpatient hospital use.

Goldsmith now is president of Health Futures, Inc., and associate professor of medical education at the University of Virginia School of Medicine. Goldsmith, who earned his Ph.D. in sociology at the University of Chicago studying complex organizations, remains one of the industry’s best known futurists. Looking back over these two decades, Goldsmith said that hospitals fought managed care plans to a draw, while losing ground to ambulatory care and competing providers of surgery and high-tech imaging. Hospitals staved off the perceived threat of physician management companies—which sought to take the hospitals’ place in negotiating payment terms with managed care plans—by aggressively buying up physician practices and then taking their losses as that industry collapsed. “Hospitals suffered major economic harm from steep managed care discounts and subsequently from the Balanced Budget Act” (BBA), which cut Medicare payments by tens of billions of dollars, he said. The hospital industry also went through a frenzy of mergers in the 1990s, much of it propelled by fear of the aggressive acquisition strategy of the former Columbia-HCA chain, which “had as its explicit corporate charter converting ineptly managed nonprofit hospitals into investor ownership.”

Nonetheless, “despite two decades of stomach churning uncertainty, hospitals have succeeded in retaining their central place in most health care markets,” Goldsmith said. Hospitals’ share of the health care dollar fell, but revenues quadrupled to more than \$450 billion. He likened their tactics to the suffocating, successful defense played by the National Football League’s 2001 Superbowl

champion Baltimore Ravens. But those victories came at a steep price: ruinous price concessions to managed care, hasty mergers, and fractured relations with physicians. “The big question for the next 10 to 15 years is: Can they learn to play offense as well?” said Goldsmith.

“Hospitals are generating operating margins short of 2 percent,” said Goldsmith. “If replacing your capital costs 3.5 to 4 percent, and you’re only generating returns of 1.5 or 2 percent, what you’re really doing is liquidating your capital. Hospitals actually are burning up their capital base.”

Largely unscathed in the 1993–94 battle over the Clinton national health plan, hospitals were caught off guard by HIPAA and by the Balanced Budget Act, which cost twice as much as the White House and the Congressional Budget Office said it would. Goldsmith said hospitals countered the threat of the physician practice management industry by buying up physician practices themselves and suffering the enormous losses that ensued. It was bad for the hospitals, but worse for the physician management industry, which collapsed in 1998. The threat from Columbia was defused by the government’s fraud fighters. Mergers, which peaked at more than 350 in 1995–1997, three years later had dropped back under 150. Hospitals came to rue the concessions they made to managed care plans, but consolidation left them in better bargaining position against health plans, which underwent consolidation of their own. Goldsmith likened the current situation to a “World War I poisoned battlefield where there are fixed positions. Incentives are perfectly aligned: neither payers nor providers want to give up economic concessions in order to gain market share. If they’ve already got 40 percent of the market, what’s the point?” In many ways, he added, “the 1990s represented a flight from competition, both on the payer and provider side.... Unfortunately, in the aftermath, hospital services, especially outpatient services, have displaced prescription drugs as the most rapidly growing item in the health care market basket.”

While hospitals rapidly expanded their outpatient departments, hospitals have lost a significant share of outpatient care and high-tech imaging since the 1980s to free-standing competitors and physicians, said Goldsmith. Downgrades of hospital debt have exceeded upgrades in all but two years since 1988. However,

rancorous relations with physicians are “the largest problem,” Goldsmith said.

“Hospitals do not rest on a sound economic footing. They are not built on bedrock. They are built on swamp land,” he said. “We’re having an epidemic of heart hospitals in this country right now, driven by physicians’ wanting to control their own destiny.” Goldsmith said he has never “seen physicians more demoralized or divided.” Hospitals must find ways to regain physician trust and support, or they face “a very significant long term threat,” said Goldsmith. If hospitals don’t “add offensive weapons to their quiver, they stand a chance of going the way of the labor unions, that is, being entrenched, extremely powerful entities committed to hanging on to what they have, but not being able to demonstrate that they are continuing to add value to the society.” Hospital leaders should be deeply concerned with the prospect “of fighting endless rearguard actions against private health plans and the government, and fighting continued erosion of profitable services from their institutions by continually saying, ‘Well, these services belong to us. They are ours. Just reimburse us for our costs and leave us alone.’ That is not a viable response,” said Goldsmith.

At the same time, reports such as the Institute of Medicine’s “To Err Is Human” have made the public and regulators more conscious of mistakes blamed for thousands of deaths in American hospitals each year. Many errors are due to hospitals’ anachronistic reliance on paperwork and telephone calls to share information among health professionals. “We’re wasting a lot of dollars in our hospital system on clerical tasks that could be digitized, rather than continuing to use paper and telephone to manage patient care,” said Goldsmith.

What new arrows could hospitals put in their quivers?

“Who controls the emerging idea of genetically based customized medicine is up for grabs,” he said. “Many believe our ability to genotype viruses or cancer cells or other pathogens in body will enable hospitals to craft custom therapies, whether vaccines or other forms of interventions.” The market for genetic tests alone doubled to \$2 billion in just the past year. Also, hospitals “could play an important role in the emerging field of regenerative medicine. Indeed, regenerative interventions in arthritis, heart disease, spinal cord injury, degenerative diseases of the nervous system and other areas... (could) replace coronary artery bypass graft surgery as the signature service for our nations’ tertiary health facilities,” Goldsmith said. And hospitals, not physicians, are best positioned to provide the around-the-clock monitoring that new outpatient devices and implants require.

Goldsmith predicted that if consumers are paying more health bills out of their own pockets, that will “choke off a lot of the procedure boom we’ve seen.” It will put pressure on hospitals “and

raise bad debts,” Goldsmith said. “Hospitals clearly are in the gun sights of this shift to consumer-directed care.” Consumers who are footing \$1,000 to \$3,000 of a hospital bill themselves also will expect better service.

Goldsmith said the current capital crunch and crowding in hospitals confronts executive with a strategic problem. Hospital boards are feeling pressure to build beds that may not really be needed for 20 years, at the expense of making overdue investments in information technology to wean hospitals from paper “and reduce a lot of the absurd bureaucratic process that’s encrusted itself on medicine,” Goldsmith said. Hospitals need to think strategically and “develop alliances and relationships with tech companies, biotech firms, the pharmaceutical industry. That’s where the future is. People have got to be willing to go out and meet that future.”

“Innovation both in clinical and management processes is vital to renewing and strengthening the hospital’s franchise,” he said. “The American hospital is an extraordinarily powerful and successful social institution. But it is also a fragile, complex social system filled with complex, highly strung, difficult to manage professionals. This social system has been strained almost to the breaking point in the last ten years by market turbulence and economic pressures. Finding the means to reintegrate professional and managerial values in service of the patient and community, while improving patient safety and service standards, is the fundamental challenge facing hospital leadership in the coming decade.”

## II. FUTURE DEMAND: DEMOGRAPHICS AND PATIENT CARE

**Presenters:** *Stuart Altman, Chairman, Council on Health Care Economics and Policy, Sol C. Chaikin Professor of National Health Policy, Heller School for Social Policy & Management, Brandeis University*

*Uwe E. Reinhardt, James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University.*

**Moderator:** *Paul Ginsburg, President, Center for Studying Health System Change*

**A**s a reminder of just how difficult it is to forecast hospital utilization, Paul Ginsburg noted per capita use grew by 8 percent in 2001 not so long after four straight years in which utilization fell. It has subsided since 2001, but the Advisory Board, which specializes in strategic research for the health care industry, has suggested that the country may need as many as 1,000 to 5,000 new hospitals—a forecast that both Ginsburg and Jeff Goldsmith have disputed.

The Office of the Actuary in the Center for Medicare and Medicaid Services makes 10-year projections of national health expenditures to guide budget making for the government's huge health insurance programs for the elderly, the disabled and low-income families. Using the gross domestic product as a deflator, hospital spending has risen from \$50 billion in 1961 to \$450 billion today. The Office of the Actuary has projected that between 2000 and 2012 that figure will rise 55 percent to \$604 billion. However, using their own assumptions, Altman and colleagues at Brandeis University forecast a steeper growth curve that would lead to 78 percent growth and hospital spending of \$692 billion by 2012.

Altman noted that despite the sharp growth in outpatient services, more than 33 million patients were admitted to hospitals in 2001, up from fewer than 31 million in 1992. "The hospital has maintained its power base within the system," he said. Most of the difference between the Brandeis forecast and the official forecast is due to this recent spurt in the per capita growth rate. Technology is the main culprit in pushing hospital prices up faster than inflation. Population growth and aging also play a small part.

Contrary to popular assumption, the group for which health care spending is rising the fastest is not the elderly, but the baby boom generation, those ages 31 to 50, Altman said. "The question before the house is as this group ages...will this (trend) continue?" Altman asked. If it does, spending will be even higher than the Brandeis forecast.

Will future advances in technology increase costs—as most technology to date has done—or decrease costs? Altman said

so-called "full technologies"—vaccines that prevent diseases or breakthrough drugs to cure cancer or prevent Alzheimer's disease—could reduce costs. But "our general feeling is that full technologies really are not yet prevalent. New technology seems to increase costs" by stimulating demand for both old and new services.

Altman said that 65 percent of the spurt in spending is likely to be on the inpatient size. The Brandeis middle estimate translates into a need for 185,000 more hospital beds by the year 2012, an increase of 22 percent.

In summary, he said, "we're suggesting that future spending for hospital care, both inpatient and outpatient, should see substantial growth in the next decade." Citing figures from 1965 to 2000, Altman said, "the American health sector each year expects to be fed 4.5 percent in real purchasing power per American than it got the year before."

The aging of the U.S. population—including the graying of the baby boomers, who start turning 65 in 2011—turns out to be "only a minor driver of the annual growth in health spending," he said. Population growth is a slightly bigger factor, but both are dwarfed by annual health spending increases for all groups.

"If Americans are really interested in controlling future health spending, they should stop looking at uncontrollable demography as the main culprit and seriously explore the cost-effectiveness of this nation's health spending," Altman said. If health spending keeps growing at this rate, by mid-century the country will be spending "somewhere in excess of 40 percent" of the gross domestic product on health care. (The Office of the Actuary calculated that the nation spent 14.1 percent of GDP in 2001 on health and that share will reach 17.7 percent in 2012).

Princeton economist Uwe E. Reinhardt said this conference should finally lay to rest the common misconception that the aging of the population is the major driver of health costs.

In Reinhardt's view, the future for hospitals is bright, now that the industry has neutralized managed care and other "weapons

of mass destruction.” Picking up on Altman’s calculation of how much more hospitals spend each year, he added, “The American health system is just like a big beast that...wants 4.5 percent more meat per living American than the year before, year after year. And if that doesn’t happen, as it didn’t during the managed care era, then they’ll whine and cry,” Reinhardt said, but ultimately “they always go into the forest, lick their wounds and then come out again fighting.” Over the past three decades, while the gross domestic product was growing 1.55 percent a year, health spending consistently has risen 3 percentage points a year faster.

“Another way to remember that, roughly speaking, is that every time GDP per capita rises by 10 percent, the health spending grows by about 14 percent,” Reinhardt said.

He believes the growing economy can absorb this extra spending for the next 10 to 20 years, if not forever. “That is one of the problems with cost containment. We don’t have to do this,” said Reinhardt. Whether it makes sense to allow the health spending to keep growing this much “is another issue.”

He recalled that a decade ago, when Congress was embroiled in debate over the Clinton health plan, the Congressional Budget Office projected the country would spend 18.2 percent of GDP on health by the year 2000. It turned out to be 13.3 percent. “There is some danger in extrapolating those trends, and that’s my point here,” said Reinhardt. “The reason the CBO was off is managed care came along and did something in that period. But these are always risky business. Even giants in the field make mistakes.”

If health spending keeps growing 3 percentage points faster than the economy, as it did in the past 30 years, it will hit 40 percent of GDP by 2040, Reinhardt acknowledged. But that assumes that nothing is done in the interim to mitigate that growth.

Reinhardt said the academic literature already was full of studies “that say aging doesn’t really matter, and yet no one seems to have grasped it.” Instead, healthcare speakers often feed audiences’ paranoia by invoking the specter of the huge baby boom generation about to engulf hospitals. But if you chart discharges per capita, the impact of the baby boom generation “is not a tsunami, it’s a ripple,” said Reinhardt. “You could never surf on this.” If you calculate what effect the boomers’ retirement will have on health spending, it may add 0.5 percentage points to annual growth, compared to the 5 to 6 percentage point growth for technology and other factors, he said.

Although Americans consume more health care than any other nation, that spending does not translate into longer lives, Reinhardt said. Not only are there sharp discrepancies between what this country and other countries spend on health, but there are huge disparities within the United States. Medicare spent \$3,404 on the average beneficiary living in Appleton, Wisconsin, in 1996, \$5,949 in Boston and \$9,033 in McAllen, Texas.

“If we shifted more toward the wheat belt (spending) model, aging would be even less of a problem. If we shifted more towards the Miami, Louisiana, Texas, El Paso model, we really will have a problem,” Reinhardt said.

He lamented that use of labor-saving capital and information technology to cut costs is “pretty much unheard of in the hospital systems.” When choosing whether to spend capital on a new building or a computer upgrade, they always choose the building “because you don’t get rewarded for having good information technology. People pay you even if you have lousy IT. There’s no market pressure for that,” he said.

He noted a recent Lou Harris survey found that nearly every doctor in Finland was fully wired into patients’ clinical medical records, and 90 percent of general practitioners in England were able to prescribe drugs over wireless connections to pharmacies. “Here it’s still paper,” said Reinhardt. He predicted that IT-savvy medical practitioners in Europe and Asia will leapfrog their U.S. counterparts unless the system is pressured to start rewarding providers for IT advances.

Reinhardt said the official 10-year forecast from the Office of Actuary assumes some slowdown in the growth of health spending. That might happen, but Reinhardt said “I see no cost control mechanism on the horizon.” Ginsburg, the moderator, said the CMS actuaries “assume there is going to be a response to the rapidly rising increase in costs.”

Altman cautioned that whatever the response, it takes time to work. When health spending accelerated in the 1980s, “it took a whole decade for us to respond,” he said. “It wasn’t until 1992, when managed care really caught on, that the spending growth really leveled off.”

Reinhardt said at some point businesses will balk at paying the double-digit premium increases they have been hit with lately. They may try to push more of the costs onto consumers, but the really big medical bills are for catastrophic care that health plans usually pay. Ultimately, he said, we may see a repeat of what transpired after the 1988 election when businesses such as Bethlehem Steel pleaded with the incoming Clinton administration to do something about their health insurance burden.

“We got the Clinton (plan) because business people had asked for it. Remember Little Rock? It was full of corporate jets with people pleading, ‘Please do something, Mr. President.’ Maybe they’ll all come begging. This is the rule of American public policy. When the going gets tough, the tough run to the government,” said Reinhardt. “It may happen that in 2006, 2007, you’ll have all kinds of corporate jets at Reagan Airport with people pleading to the government to help bail them out, particularly on retiree health care.”

### III. FUTURE SUPPLY: CAPITAL, TECHNOLOGY AND WORKFORCE

**Presenters:** *Frederick E. “Rick” Wolfert, President and Chief Executive Officer, GE Healthcare Financial Services*  
*Richard L. Clarke, President and Chief Executive Officer, Healthcare Financial Management Association*  
*Peter I. Buerhaus, Valere Potter Professor of Nursing and Senior Associate Dean for Research, Vanderbilt University School of Nursing*

**Moderator:** *Kathleen A. Buto, Vice President for Health Policy, Government Affairs, Johnson & Johnson*

**A**fter dwelling on the demand for hospital services, the conference turned its focus to difficulties that hospitals face over the next decade in attempting to supply those needs, including the growing demand for capital to build new facilities and purchase new technology, and the human capital required to staff these facilities. As moderator Kathy Buto observed, “What this session could really be called is Needs and Resources.”

In a shared slide presentation, Rick Wolfert, president and CEO of GE Healthcare Financial Services, and Richard L. Clarke, president and CEO of the Healthcare Financial Management Association (HFMA), outlined the current scramble for capital and suggested some best financial practices for hospitals’ seeking to buttress their case for capital.

Earlier, Uwe Reinhardt had drawn laughs when he relayed a recent observation from the CEO of Blue Cross and Blue Shield of South Carolina: “He said with a straight face, ‘We categorize hospital into three classes; those with one construction crane, those with two, and those with three.’ Anyone who has hunted for parking outside a crowded hospital lately can attest to the accuracy of that quip. Wolfert provided the figures to back up such impressions. “These are watershed years for the hospital industry. The industry itself has navigated some tremendous storms—declining utilization rates, reimbursement system changes, and the loss of investment income due to a very soft stock market,” he said. “The good news is that hospitals appear to be at a turning point,” with operating margins improving. But those margins “are not nearly large enough to burgeoning demand for capital investment,” Wolfert added. He forecast “a tremendous battle for capital” ahead.

“There are going to be winners and losers in the system. The winners must develop strategic plans for resolving this conflict in a manner that is not only consistent with their strategic plans and vision, but also is well understood and accepted by external

stakeholders such as the rating agencies and the financial institutions that are lending significant amounts of money to them,” said Wolfert, a former president and chief operating officer of Heller Financial.

Noting that inpatient utilization grew 3 percent between 1999 and 2001, Wolfert said demand for hospital beds probably will grow 1.5 to 2.5 percent a year “for the foreseeable future.” Outpatient visits and procedures—now running at 600 million a year—are likely to keep growing at 3 percent. The reimbursement picture is “somewhat mixed,” with 37 states planning to freeze or reduce Medicaid reimbursement rates after a 13 percent jump in Medicaid spending last year. Fifteen states also are considering curtailing Medicaid benefits. “It’s clear that this revenue source is going to be under a tremendous amount of pressure,” said Wolfert. In the private sector, the big increases that hospitals have wrested from managed care plans lately “are not sustainable and perhaps have peaked.” Employers and labor alike already are balking at premium increases.

At the same time, hospitals are facing shortages of skilled labor, including registered nurses and pharmacists, and that is driving up costs, Wolfert said. Premiums for medical malpractice insurance are skyrocketing, and “in some cases it’s not even available,” he said. Prescription drug costs are growing at double-digit rates.

“You can see the picture evolving: Demand continues to be very, very strong. Revenues are under a tremendous amount of pressure and guess what? There are all sorts of drivers in terms of the cost equation. From a financial standpoint this is putting an awful lot of pressure on the system,” said Wolfert. GE Healthcare Financial Services recently surveyed chief financial officers of major healthcare systems. Their topmost concern was increasing hospitals’ cash flow and shortening the revenue cycle. They were also worried about the adequacy of Medicare and Medicaid reimbursements, liability costs, and making the investments necessary

to improve patient safety and productivity.

While the recent jump in inpatient admissions has improved hospitals' operating margins, hospitals' income from investments has fallen with the rest of the market, so total margins have continued to decline, Wolfert said. With the average plant nearly 10 years old, pent-up demands for capital improvements are exploding, he said. "Customers and physicians are demanding newer, more patient-friendly facilities." Wolfert estimated that \$22 billion to \$24 billion in new projects will be launched this year, and \$69 billion in construction will be completed or underway in the coming year. A third of these new projects (\$8 billion to \$9 billion) are for outpatient facilities and specialty hospitals. Those specialty hospitals pose a threat because they often take the most profitable procedures away from community hospitals.

"There's a tremendous amount of activity taking place," said Wolfert. "The big question for all of us is how is this going to be paid for and what is the impact going to be on the overall financial condition of the healthcare system?"

Hospitals will invest more than \$20 billion this year in information technology. After meeting the challenges posed by the Y2K problem and compliance with HIPAA, "now we're really getting more into the clinical side of the equation in terms of patient safety and improving productivity. This has been pent up," he said.

While hospitals obtain \$20 billion to \$25 billion in financing through the bond market each year, "a lot of institutions are being boxed out of the bond market or finding it much more difficult to access the bond market," said Wolfert. Almost half of hospital credit ratings are BBB or below. Credit downgrades exceed upgrades, despite the recent improvement in operating margins. When hospitals take advantage of low interest rates to refinance their debts and meet their capital needs, that additional debt itself is enough to lower their credit ratings. Wolfert said the industry is becoming polarized, with "some very strong, healthy hospital systems that have figured out a way to navigate these waters and build strong financial statements," and some "very, very vulnerable institutions that are running out of cash, that are highly leveraged and are having a very difficult time responding to a very competitive marketplace." Some of the latter are approaching non-investment grade status in the bond markets. A lower credit rating "can cost hospitals millions over the course of the 20-to-30 year financings that not-for-profit hospitals prefer," he said.

"Capital is scarce and it's going to take much more sophisticated financial strategic planning to come up with realistic plans that are sellable not only to the boards of these institutions but, perhaps more importantly, to the outside investment community that's going to be asked to provide capital in the form of debt and equity to make all these dreams come true," said Wolfert.

Richard Clarke, who heads an organization with 70 chapters

and 31,000 members in hospital financial management, offered suggestions on how hospitals can improve their financial picture, including:

- Controlling costs and enhancing revenue to improve liquidity
- Improve capital allocation
- Managing the assets and liabilities on their balance sheets to meet strategic goals
- Using creative financial products to generate cash for projects without damaging their credit rating

"Capital finance is not purely debt. There are a whole variety of methods of financing projects that include things such as leases and joint ventures and REITS and other vehicles," said Clarke. He offered the example of Advocate Health Care, a system with eight hospitals and \$2 billion in revenue in the Chicago area. Advocate looks to fill its capital needs not only through borrowing, but by tapping its internal pool of money, including income from its operations, investment income and philanthropic gifts.

Financial experts regularly counsel hospitals to shed non-strategic assets. "Sell them, lease them, do something that will create a cash flow from those assets" so the money can be used for strategic purposes, Clarke said. Advocate did that in 2002 by selling off physician office buildings, nursing home, and other properties for \$60 million. It also took out a \$25 million master lease line. This freed up capital without Advocate's having to go into the bond marketplace.

Clarke said hospital managers should look carefully at the return on investment from all their institution's activities, including those that are not expected to return a profit. "There is profitless volume and cashless utilization. There are things that you have to do that don't necessarily generate revenue, but overall you still have to look at the return on investment, especially if you're pulling cash out of a different or alternative investment vehicle," he said. "You have to be able to replace that income from that return."

Institutions adept at handling their finances keep this in mind even when they undertake activities meant to fulfill their mission of community service or meet HIPAA requirements. Nothing is done in isolation. "These better practice organizations look at how they can link" these efforts to enhancing their volume and profit down the road, perhaps by improving productivity, or improving outcomes for patients," said Clarke. Hospitals should balance low- or negative-margin projects with profitable projects, he said, and scrutinize all projects regularly reassessed to make sure they adhere to their stated goals.

In his earlier days as a hospital finance executive, Clarke said, "I found that when they'd bring these projects to us, they'd say, 'Oh, these are great projects; they're going to return a wonderful

amount of money on the bottom line.' We'd get into the project and it kind of oozed into, 'Well, this was a community need-based project. This really wasn't an investment return. This was mission-related.' You had to be careful about how projects might move from one category to another simply because they were not performing as expected."

Hospitals need to keep lines of communication open with rating agencies and lenders. "This is something I don't think the non-profit industry has done as well as the investor owned industry," he said. "Make sure that they understand what you are doing and believe that you are being transparent to them in the information you are providing."

Clarke closed by reiterating the importance of hospitals' developing a strategic plan of finance linked to the organization's operating plan, and carefully weighing both their demand and capacity for capital. If that capacity proves inadequate, "then we as a society and as individual organizations are going to have to make very hard choices on how to allocate those scarce resources."

### **Hospital Staffing Problems**

Peter I. Buerhaus, a professor of nursing and senior associate dean for research at Vanderbilt University School of Nursing, presented a sobering look at the personnel trends in this industry with more than 200 health-related professions or occupations. Hospital vacancy rates for pharmacists, imaging technicians and nursing assistants exceed 10 percent and are nearly that high for lab technicians and coders. In one hospital survey, 38 percent of hospitals said these shortages were causing overcrowding in emergency departments, 23 percent had reduced the number of beds they staff, and 19 percent reported longer waits for surgery.

The number of pharmacists is expected to grow from 196,000 in 2000 to 224,500 in 2010. But applications to pharmacy schools have been declining since 1994. Three decades ago, fewer than 1 in 8 pharmacists were women. Now women comprise almost half the pharmacists, and two-thirds of pharmacy students. Almost 30 percent of the nation's pharmacists work in hospitals. The drivers of the current shortage of pharmacists include increased demands, unpleasant work conditions, and a tendency by women to limit hours worked, compared to their male counterparts.

On the physician side, Buerhaus said there are anecdotal reports of spot shortages, with difficulties recruiting radiologists, orthopedic surgeons, anesthesiologists and cardiologists. This comes after years of efforts by the federal government and the Council on Graduate Medical Education to discourage medical students from becoming specialists. Richard Cooper, M.D., director of the Health Policy Institute at the Medical College of Wisconsin in Milwaukee, has sparked controversy with his contention the nation may be short 50,000 physicians by 2010 and as many as

200,000 by 2020 (Cooper's stance has not gone unchallenged; Stuart Altman remarked earlier that the United States is still producing physicians "like rabbits.")

Buerhaus said the United States may need to import foreign workers to fill vacancies in the ranks of nurses and pharmacists.

Some 1,270,000 registered nurses work in U.S. hospitals and 126,000 RN positions, or 13 percent, are vacant. In a recent survey, nurses reported that these shortages, which began in 1998, were having a negative impact on the patient care, safety, their ability to detect complications early, and the time available for collaboration with colleagues. In fact, 9 out of 10 RNs say that the shortage has reduced the amount of time they have to spend with patients.

Why are so many nursing jobs unfilled? Buerhaus said the economy was an important factor. Even as demand for inpatient and outpatient services rose, nurses' inflation-adjusted earnings decreased for four years in a row from 1993 to 1997. Hospitals cannot readily substitute other workers for RNs. The strong economy in the 1990s also led some nurses to curtail their hours or drop out of the profession. Seventy percent of nurses are married, he noted. "What happens to spouses' incomes or their feelings of security about jobs plays a very important role on the decision of RNs to be in the market and how many hours they will work," he said. Also, fewer women are in their 30s, an age when many entered two-year nursing programs in the past. Women have wider career choices these days. The result is an aging work force. Sixty percent of nurses now are 40 or older and the average age of hospital nurses is 42. Young nurses are harder to find. Between 1983 and 1998, the number of RNs under age 30 dropped 41 percent.

Buerhaus said the number of RNs is expected to grow slowly for five to seven years, flatten out then shrink after 2012, with shortages estimated between 400,000 and 800,000 by 2020. By 2010 the largest group of nurses will be in their 50s. "There's good news that in the future we will have a very educated, very experienced, good decision making, lots of knowledge and experienced RNs. But they are going to be trapped in these 50-year-old bodies," he said. "Already the workforce injury data is staggering."

In addition to bringing in more foreign nurses, wages will have to go up sharply, he predicted. The nurse shortage has ominous implications for patient care and outcomes, as recent studies have found direct links between hospital nurse staffing and mortality, bed sores, infection, patient satisfaction, errors, falls, length of stays, thrombosis and cardiac arrest. Buerhaus said, "I think it will mean hospitals will have to invest much more in providing stable, good nursing care lest they be vulnerable in the marketplace for not being able to show good outcomes that are nurse-sensitive."

Moderator Buto asked the panel what hospitals' increasing dependence on Medicare will mean for the availability of capital

over the next five to ten years. “It’s a fairly stable payment methodology. You can count on it,” said Clarke, but Medicare’s rates often are inadequate. It “doesn’t build in enough margin to build the capital reserves to be able to replace facilities in the future.” Wolfert said top performing institutions “seem to manage their mix of business quite well” so they have both private and public pay patients. Hospitals that depend primarily on Medicare and Medicaid reimbursement often are financially weaker.

David Shactman, project director of the Council on Health Care Economics and Policy, asked if this scramble for capital works to the relative advantage of for-profit or not-for-profit hospitals.

Wolfert replied that for-profit hospitals currently are doing “a much better job of framing a business case, a business strategy and bring more sophisticated perspectives in how they’re going to navigate through that.” Successful for-profit hospitals are running 8 to 9 percent operating margins, while non-profits are in the 2 to

3 percent range, he said. “My gut instinct is that capital is going to flow to those business models that have stronger operating margins, because your probability of getting repaid is higher,” Wolfert said. Not-for-profit hospitals may have to adopt “some of the strategies that some of their peers have already put in place.”

If hospitals cannot readily substitute other workers for registered nurses, is there any way to restructure tasks so they are not hobbled by the shortage of RNs, asked Gary Filerman of Georgetown University’s School of Nursing & Health Studies.

Buerhaus replied that hospitals must find ways to use other workers more efficiently and to make nurses’ job less taxing. “We need ergonomics to keep the older nurses in,” he said, and hospitals need to get nurses’ aides more involved in patient safety and ensuring the quality of care. These aides need to “see their whole role in a much greater way than just passing out trays and doing menial tasks, but becoming more involved in the care of patients.”

## IV. INTEGRATED MEDICAL CARE

**Presenters:** *Harold S. Luft, Caldwell B. Esselstyn Professor of Health Policy and Health Economics and Director of the Institute for Health Policy Studies, University of California, San Francisco*

*R. Adams Dudley, M.D., Associate Professor, Institute for Health Policy Studies, Department of Medicine and the Department of Epidemiology and Biostatistics, UC, San Francisco.*

**Moderator:** *John K. Iglehart, Editor and Founding Editor, Health Affairs*

Finding ways for hospitals, physicians and other providers to integrate delivery of clinical care has been a holy grail that many have searched for and few have found, Chip Kahn noted. Why have so many of these efforts to improve efficiency and quality by carefully coordinating care failed? Is the integration of clinical care a pipedream or can the obstacles that have thwarted past efforts be overcome?

Harold Luft and R. Adams Dudley of the Institute for Health Policy Studies at the University of California, San Francisco, presented a detailed analysis of what went wrong with past integration experiments and proposed a prototype for moving forward. Picking up on Jeff Goldsmith's admonition to hospitals, Dudley said they hoped to describe "what a good offense would look like."

"Logically you just can't argue against clinical integration," said Dudley, a physician. "Everyone can imagine that it would be useful to have seamless care, to have information flow from inpatient to outpatient provider and back again just as patients flow from inpatient to outpatient providers and back again."

The key "is collaboration across services and settings," so that all the providers work closely together to set up care in ways that maximize quality, lead to the best patient outcomes and achieve efficiency. But "that isn't the way the world is going. If anything, the world is going away from integration," said Dudley. Group and staff model HMOs are not gaining market share, and the physician-hospital organizations of the 1990s were "disasters," he said. Integration efforts can be exhausting. "Should we just give up?" he asked rhetorically.

Luft and Dudley believe not. There have been some isolated successes, and they believe that integrated clinical care can work if doctors are not asked to do things they are not trained to do, such as underwriting and taking on full risk. Dudley pointed to the Department of Veterans Affairs health system as an example of both the pitfalls and promise of integration. The VA's efforts to integrate care across its hospital and clinic settings were clearly a

failure early on, he said. Then, after a management change in the mid-1990s, "in the space of just three or four years the VA went from worse to dramatically better" than hospitals providing comparable care to Medicare patients, he said. The VA introduced uniform information technology throughout the system, installed performance measurement and reporting, and provided regular comparisons of hospitals and providers across entire regions. Dudley, co-author of a forthcoming paper on the VA experience, said integration facilitated the management drive for improved performance, but it cannot be said that integration by itself deserved all the credit.

Most physician hospital organizations created in the 1990s to accept capitated payment from managed care plans were failures, Dudley said. They usually were preoccupied with administrative and management issues, such as claims processing, coordination of benefits and how to price services. "These are all health plan functions," he said. "There were inefficiencies in almost every case. They just multiplied by the number of organizations the number of committees they had (and) the number of staff they needed to manage these things." Their primary mission was financial. In interviews with more than 25 such organizations, Dudley said, "not once did they start out with 'Here's what we did for care; here's what we did to make things better in our local health care system.' It was all about 'Here's how we managed things.'" With no compelling medical mission and paltry incentives, it was practically impossible to convince doctors to change the way they did their job.

"The PHOs basically were asked to be a health plan" and to take on both the risk of occurrence of clinical events, such as cancer, strokes and heart attacks, as well as the risk of clinical management, or how efficiently they could deliver care after a patient had been diagnosed with lung cancer or another serious condition, he said. These are not risks that physicians are accustomed to shouldering. "It was asking people to climb much too high a mountain," Dudley said.

What might work?

Small groups of providers could adopt a viable, compelling mission, with clinical goals such as improving care for patients with asthma or congestive heart failure, Dudley said. They should not try to take on the entire medical spectrum of problems. Dudley and Luft believe a medical group could enlist a large payer, such as the Center for Medicare and Medicaid Services, to undertake this as a demonstration project. The payer, not the providers, should bear the risk of occurrence. Under the Luft-Dudley protocol, payment would be triggered by an episode of care that includes a hospitalization, and that payment would vary by the diagnosis. The episode would include pre- and after-care, with incentives to use the optimal setting and avoid repeat hospitalizations. The demonstration project still would have to overcome logistical and legal barriers over which entity gets the

payment and how it is shared among providers. Under current law, such arrangements might be regarded as illegal kickbacks. “You have to figure out a way not to be running afoul of those laws,” Dudley said.

What role should the hospital play *vis a vis* the physicians in setting up such a demonstration, Chip Kahn asked.

“It would need to be a collaboration,” said Luft. With congestive heart failure patients, the hospital might be paid a little more for the first hospitalization, but less if the patient were readmitted. They would use the extra money to hire more nurses to monitor the patients more closely in the hospital and make sure they get the follow-up care, including the right medications and diet, to avoid a relapse. While the payment might go to the hospital, Luft said, physicians would be making the key clinical decisions.

## V. PATIENTS/CONSUMERS AS THE NEW THIRD PARTY IN HEALTH CARE

**Presenters:** *Lawton R. Burns, The James Jo-Jin Kim Professor and Professor of Health Care Systems and Management, The Wharton School, University of Pennsylvania, and Director of the Wharton Center for Health Management & Economics*

*David Nash, M.D., The Dr. Raymond C. and Doris N. Grandon Professor of Health Policy, Office of Health Policy & Clinical Outcomes, Thomas Jefferson University*

**Moderator:** *Charles N. Kahn III, President, Federation of American Hospitals*

Early in his slide presentation, David Nash, M.D., of Thomas Jefferson University in Philadelphia, showed a picture he took on a recent family vacation of tourists crowded around the glass-encased Rosetta Stone in the Rotunda of the British Museum in London. The point, said Nash, an authority on ways to improve the performance of hospitals and physicians, was to underscore that “there is no Rosetta Stone to sort out hospital-physician relations.”

“Historically, the physician and hospital view of patients was rather dim, to say the least,” said Nash, an internist. “The patients were products they worked on: The Gall Bladder in Room 201. We still talk that way.”

In terms popularized by the German sociologist Georg Simmel (1858–1918), hospitals and physicians were part of an economic dyad. “Every community hospital in our country is organized for one social group, and it’s not the patient,” said Nash. Patients were ignored as a customer per se, lacking power and information about their health care. That now has changed dramatically, with the patient as consumer poised to play a critical third party role in a relationship that in Simmel’s terminology is now a triad.

The triad is a more complex structure for these relationships. Nash said a third party traditionally plays one of three roles:

- A mediator or arbitrator between the other two parties
- An oppressor who divides and conquers the other parties
- An “enjoying third party”—a *tertius gaudens* in Latin—that turns dissension to its advantage as the other parties bid for its support.

Nash said that for much of the 20th century, hospital boards played the role of mediator between hospital and physicians. From 1980 to 2000, managed care firms and other big payers became the third party oppressors. And now, since 2000, patients have emerged as the “enjoying third party” who can attempt to play the

hospital and doctors against each other.

The rise of managed care turned a symbiotic relationship between hospitals and doctors “into a much more competitive one,” said Nash. Hospitals in the 1980s created profit-making subsidiaries and erected formal administrative hierarchies. Hospital directors became CEOs. Hospitals centralized decision making and expanded outpatient services. Physicians saw these moves as infringement on their clinical autonomy.

Then managed care emerged as the dominant payer and pushed both hospitals and physicians around. The latter formed physician hospital organizations and other “weird” arrangements, Nash said, in futile efforts to retain leverage in negotiating contracts. “The whole notion of putting together integrated delivery networks in the Philadelphia area was to counter the bargaining power [of] Independent Blue Cross and U.S. Healthcare, Nash said. “The idea of clinical integration was not even on the radar screen.” There is no evidence that provider-sponsored health plans succeeded anywhere, he added.

Holding doctors accountable for the health status of entire populations made no sense to the physicians, said Nash. That “flies in the face of our current medical school teaching structure of one patient, one problem, one at a time. You can’t ask people who have a sworn oath to do everything they can for the individual sitting next to them in the examining room to take into account the population issues.” He also scoffed at the notion physicians could view cost containment as part of their jobs. “I always think of this as akin to giving my 17-year-old twin daughters my credit card and saying, ‘Go to the King of Prussia Mall together and contain costs,’” he said. Being more efficient and decreasing waste should be goals, “but we didn’t have those words in our vocabulary” in the 1990s, Nash said. Many physicians still bristle at attempts to benchmark and measure their performance.

But in this new consumer era, hospitals and physicians are under heavy pressure to improve quality and report errors. Nash noted that the Federation of American Hospitals and the American Hospital Association recently joined with the Association of American Medical Colleges to endorse a voluntary system of hospital report cards. The real epidemic that threatens public health is not SARS but all too common and deadly medical errors, he said.

Nash decried the proliferation of physician-owned “niche” hospitals that seek to take the most profitable patients and procedures away from community and teaching hospitals. “As long as the physician monopoly on the hospital admission process continues,” he said, hospitals must find ways to repair and rebuild relations with their medical staffs.

Stuart Altman said that consumerism is “a pretty weak rod” to discipline the free-spending U.S. health system after everything else has failed. “I can think of 20 reasons why consumers don’t want to be in this game,” said the Brandeis economist. Lawton Burns agreed that consumerism is “a pretty weak hook.” A recent survey of community tracking centers by the Center for Studying Health System Change underscored that point. Burns, a former hospital manager himself, said hospital executives need to treat physicians as customers as well, as they once did. “If I had one

sentence to say to hospital executives, it would be that. Hospital administrators get no training on understanding what makes physicians tick, and applying behavioral science to working with this very difficult profession. That’s where I’d put all my investment,” Burns said.

Chip Kahn said that discussion of outcomes and accountability once never went beyond the doctors’ lounge, and the information “was all hearsay. Now the hospital administration or the corporate headquarters knows which bypasses are working out and which aren’t and what the infection rates are. Will this change the hospital-physician relationship?”

Nash said Pennsylvania’s hospital report cards, which he has studied, were “a mixed bag. The really poor performers were called to task and over three to four years, those institutions, with the physicians in tow, actually did improve.” But he questioned whether those hospitals would have undertaken “the hard work of improvement without the glaring availability of this kind of information. I think the answer is no.”

Nash believes that hospitals’ rates of nosocomial infections and iatrogenic complications “all ought to be laid out for people to look at and ask questions about.” Consumers could make better decisions if they had that information.

## VI. WHO PAYS FOR HOSPITAL CARE AND HOW?

**Presenters:** *Hugh W. Long, Professor, Tulane University School of Public Health & Tropical Medicine, Department of Health Systems Management*

*Catherine McLaughlin, Professor of Health Management and Policy and Director, Economic Research Initiative on the Uninsured, University of Michigan*

**Moderator:** *David Shactman, Project Director, Council on Health Care Economics and Policy, and senior research associate, Schneider Institute for Health Policy, Brandeis University.*

**T**he final panel provided an overview of the outlook for hospital payments and what impact the growing number of Americans without health insurance will have on hospitals.

David Shactman, the moderator, likened the current situation, with hospitals required under the Emergency Medical Treatment and Active Labor Act of 1986 to screen and stabilize any patient who shows up in a medical emergency, to a butcher shop where customers can demand deep discounts on the finest cuts of meat or, if they have no insurance, get filet mignon for free.

Hugh Long said hospital payments will nearly double between 2001 and 2012, but still shrink as a proportion of national health expenditures. The hospital share likely will fall from the current 32 percent to 27 percent by 2012. The mix of services provided by hospitals will continue to shift from inpatient care to outpatient/ambulatory services. Most payment to hospitals will remain solidly linked to the philosophy that payment should cover the cost of resources consumed in delivering care, Long said. Whether that payment is tied to episodes of care or is made on a per capita basis, there will be continuing efforts to slow cost growth, reduce lags in recognizing the costs of new techniques/technology, and more closely match payments to variations in cost by making adjustments for risk.

The sources of payments to hospitals are relatively stable, Long said. The two largest sources are federal payments and private insurance, with state and local governments and out-of-pocket spending paying the remainder of the bills. The latter two are minor contributors. Because federal payments and private insurance represent such a large percentage of total hospital payment, they necessarily “move in opposite directions as economic times change (and) as political winds change,” he said. Medicare is a steady source, while Medicaid could be more volatile, especially with states considering ways to hold down their share of costs or curb benefits. But with the public concerned about the uninsured and with employers still bearing most premium costs, Long added a prediction that “these things won’t get very far out of whack over

time and that there will be corrective mechanisms that come into place that adjust for shrinkages or high rates of increase that may occur in the very short run.”

Long outlined the history of various hospital payment methodologies, from retrospective payment starting with Blue Cross in the 1930s to the prospective payment system that Medicare adopted in 1983. The next evolution in hospital payments will begin to address ways to tie payments to the value of the care delivered, rather than merely to the costs of that care, Long said. Challenges include how to adequately measure quality, how to reallocate risk, and how great a share patients should pay out of their own pockets.

With improved technology and treatment breakthroughs, eventually fewer hospital bills will be for catastrophic care, he said. “As that happens, I think moral hazard becomes more important...” said Long. “As the pieces get smaller, as we have more control and more time to gather information, I think that the notion of bringing control over moral hazard to the hospital sector becomes increasingly more important.” He noted efforts by the Leapfrog Group and others to encourage giving bonuses to physicians who achieve better outcomes for their patients. Some health plans already reward providers if all the group’s members get flu shots. “The next thing we need to think about is the way in which those kinds of mechanisms...may be expanded in ways that could affect hospitals as well,” said Long.

The final speaker, Catherine McLaughlin, presented a paper coauthored with Karoline Mortensen, a colleague at the University of Michigan, on the topic, “Who Walks Through the Door? The Effect of the Uninsured.” Using the Agency for Healthcare Research and Quality’s Medical Expenditure Panel Survey (MEPS), McLaughlin and Mortensen sought to answer the question of what would happen to hospitals if more Americans fell into the ranks of the uninsured. The number grew last year to 41 million, and “all health care providers are understandably concerned about the implications of an increase in the number of

uninsured persons for their financial viability,” the authors noted.

They calculated what percent of hospital visits in 1999 were accounted for by the uninsured, and how those shares would change under different scenarios. They looked not only at inpatient stays, but use of hospital emergency departments and outpatient visits. In 1999, 11 percent of the population was uninsured all year, and another 11 percent was uninsured part of the year. But those who went without coverage the entire year accounted for, on average, only 5 percent of hospital inpatient admissions, 10 percent of visits to the emergency room and 2 percent of outpatient visits.

“We estimated that a 40 percent increase in the size of that pool would result in increasing those average shares to 7 percent, 14 percent, and less than 3 percent,” the authors wrote. McLaughlin, summarizing the findings, said the uninsured are not something that “a lot of hospital administrators should be staying up late fretting about.” The uninsured are significantly less likely than the insured to be hospitalized. They also are unlikely to “swamp” emergency departments, as some hospital administrators have feared, McLaughlin said. The MEPS data showed that poor and near poor people with insurance are 50 to 75 percent more likely to use emergency rooms than those with no insurance.

While the overall impact is small, hospitals already serving large numbers of the uninsured could find their burdens growing even

heavier. While the average share of uninsured inpatient discharges is 4.8 percent, the average share of uncompensated care for the top decile of hospitals was 14.8 percent. For these hospitals, a 40 percent increase in the uninsured would mean that more than one-fifth of the patients they admitted would lack insurance to pay for the care. “In essence, those hospitals for which the uninsured already pose a severe financial burden will face further crises as a result of increases in the uninsured pool,” McLaughlin and Mortensen warned.

If there is a spurt in the number of uninsured in the next ten years, McLaughlin said those most likely to lose coverage are “the nons: the non-elderly, the non-disabled, (and) the non-pregnant. Well, guess what? They are the lowest users for hospital care.” She and Mortensen calculated what would happen if 5 percent of such people lost employer-sponsored health insurance. That turned out to be 8 million people. They then assumed that half would go without insurance for a full year and half would be uninsured part of the year. The result was only a 1 percentage point increase in the number of Americans without insurance for the entire year. The impact on emergency departments and outpatient visits would be similarly modest, she said. The effect might be larger on some inner city hospitals and emergency departments, but for most hospitals this is not going to be a major worry. “The uninsured are not the big users of hospital care,” said McLaughlin.

## WHAT WE'VE LEARNED

**I**t fell to Stuart Altman to briefly summarize the conference's main themes.

**Jeff Goldsmith's** message was that "hospitals need to change from defense to offense. They were amazing in their capacity to adjust to these forces that hit them" in the past two decades, Altman said.

Of **Altman's** own session with Uwe Reinhardt, the take-away lesson was, "It's technology, stupid....Aging is not the force that the great unwashed believe it is, though only us sophisticates know that it really isn't important," he said.

The **Rick Wolfert** and **Richard Clarke** presentations made clear that hospitals will find it hard to secure the capital they need to expand in this decade. "It's not going to be so easy to shake the [money] trees," Altman said. Hospitals have learned in recent years that "the stock market taketh as well as giveth," he said, and credit that once "looked like cheap money turned out not to be so cheap money."

Altman said **Hal Luft** and **Adams Dudley** "did a wonderful job of looking back over what the expectations were with respect to integration of clinical systems and why what sounded like such a good idea has turned out to be such a blooming failure up to now. But they raised hope that we could ultimately see it work....It ought to be done in small doses."

Of **David Nash's** talk, he said, "No wonder there's so much medical error. I hadn't realized how much the physicians hated the hospitals and vice versa, and they really didn't give a damn about the patients." But he expressed hope "that the patient will make a difference" in this equation.

Altman picked up on a remark by **Hugh Long** about the desirability of reducing cross-subsidies in hospital payments. The former ProPAC chairman said, "I'm here to tell you: Cross subsidies are better than no subsidies." It only makes public policy sense to wipe out cross-subsidies if they are no longer needed because "everybody was insured and the services we deem important, whether it's mental health services or burn centers or emergency rooms, were adequately paid for."

Finally, Altman lauded the honesty of Catherine McLaughlin's conclusions. "I'm sure Catherine went into this study convinced that the uninsured really mattered, and that this big growth in the number of uninsured was going to sink our hospital system," he said. But "she ultimately let the data win out" and presented her findings that a growth in the number of uninsured would have only a small impact on hospitals and their emergency rooms.

While it undercuts the notion that the problem of the uninsured is reaching a crisis stage, Altman said, it also strengthens the arguments of those who believe it would not be that expensive to cover the uninsured. "We could solve it without breaking the budget," he said.

P L A N N I N G  
C O M M I T T E E

**Stuart H. Altman**, Chair, and **David Shactman**, Project Director, Council on Health Care Economics and Policy

**Kathleen A. Buto**, Vice President for Health Policy, Government Affairs, Johnson & Johnson

**Robert Galvin, M.D.**, Director of Global Health Care, General Electric Co.

**Paul Ginsburg**, President, and **Cara S. Lesser**, Senior Researcher and Director of Site Visits, Center for Studying Health System Change

**Jay F. Grinney**, President, Eastern Group of HCA and Chairman of the Board of Federation of American Hospitals

**John K. Iglehart**, Founding Editor, and **Jane Hiebert-White**, Associate Publisher, *Health Affairs*

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S P O N S O R S

