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# REGULATION THROUGH THE LOOKING GLASS: HOSPITALS, BLUE CROSS, AND CERTIFICATE-OF-NEED

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This is the story of the forgotten origins of hospital certificate-of-need regulation. For nearly three decades rising hospital costs have perplexed economists and public policy experts. The principal regulatory response to rising hospital costs has been government control of hospital construction through state planning and licensing regulation, known popularly as "certificate-of-need" (hereinafter sometimes referred to as "CON").<sup>1</sup> CON has been promoted by the Blue Cross, the voluntary hospitals, and the public health establishment.<sup>2</sup> Hospital costs have continued to rise, however, and nowhere more dramatically than in New York, the state that pioneered CON. Economists have discovered that some forms of CON regulation seem actually to have accelerated the rate of increase in hospital

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1. We use the term "certificate-of-need" broadly to mean any exercise of state licensing authority with respect to health care facilities or services where the standards for the exercise of such authority are described in terms of the "need" for the facilities or services. Since this Article deals only with the origins of CON regulation, we shall not attempt to take into account its present variations. For a comprehensive compilation of state certificate-of-need statutes and federal statutes and regulations bearing on certificate-of-need requirements *see* CHAYET & SONNENREICH, P.C., *CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT* (1978 & Supp. Fall 1978).

2. As used in this Article, the terms "voluntary hospital" and "voluntary nonprofit hospital" refer to hospitals that are owned by private nonprofit enterprises and into which patients enter without legal compulsion. They are to be distinguished from hospitals owned by governments or for-profit enterprises (including sole proprietorships, partnerships, or business corporations). All of the hospitals described as "voluntary" in this Article are short-term general hospitals.

We use the term "establishment" to describe the leadership of the elite voluntary hospitals and the public health profession. The elite of the voluntary hospital sector are the administrators, physicians, and governing board members associated with the large voluntary hospitals. The leadership of the public health profession includes officials of the United States Public Health Service and the leading state departments of health, university faculty members specializing in public health or hospital administration, and officials of major hospital or health planning agencies in either the government or the voluntary sector. Unless otherwise mentioned specifically as having a separate interest, the leadership of the Blue Cross is subsumed within the elite voluntary hospital establishment (with which it had an overlapping and interlocking directorate during the period under discussion).

costs. If one believes that planning and regulation of construction were intended to stem hospital cost inflation, then one must regard CON as a failure.

But CON was not designed to be a cost containment program. CON was invented in the late 1950s when Blue Cross rate increases, made necessary by rising hospital costs, provoked public controversy in a number of eastern and midwestern states. Insurance commissioners in several states threatened to use their power over Blue Cross rates to institute hospital cost containment measures; regional planning and hospital construction controls were put forth by the hospital and public health establishments as an alternative to cost controls. The hospital and public health establishments hoped that regional planning with community involvement would help to educate the public to the increasing quality and expense of good hospital care and thereby lead to public acceptance of rising costs; they never contemplated that CON would either control costs in individual hospitals or counteract the acknowledged causes of rising costs in the hospital sector as a whole.

Regional planning and hospital construction controls were intended to achieve three related objectives that were shared by the Blue Cross, the voluntary hospital establishment, and leading health officials in both the public and the private sectors: (1) to restore public confidence in the voluntary hospitals and their financing arm, the Blue Cross, in order to deflect growing pressure for government regulation of hospital costs and government-sponsored compulsory health insurance; (2) to protect the dominance of the existing large voluntary teaching hospitals; and (3) to channel hospital growth in the developing suburbs into large, full-service, general hospitals. Although the voluntary hospitals and the public health establishment maintained that regional planning enforced through hospital construction controls would help to solve the problem of rising hospital costs, it was always clear that regional planning was being promoted for its own sake: cost control, if it materialized, would be a by-product. It was reasonably apparent to anyone who cared to think clearly, however, that cost control would be a most unlikely by-product of this form of regulation.<sup>3</sup> It would be more realistic to expect

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3. One of the most thoughtful members of the health planning profession, Symond R. Gottlieb, formerly executive director of the Hospital Areawide Planning Committee of Milwaukee, Wis. and now executive director of the Greater Detroit Area Hospital Council, has said:

Those who think of areawide health planning as a primary mechanism for reducing costs are doomed to much disillusionment — planning may redirect the use of some resources to permit their more effective use — total costs, however, are likely to increase as the

planning to cause hospital costs to rise even more rapidly, since planning was designed to concentrate the hospital industry into fewer but larger and more expensive units delivering increasingly sophisticated services to increasing numbers of patients.

Nonetheless, the proponents of certificate-of-need succeeded in persuading nearly all the states and the federal government to adopt regional planning and hospital construction controls as a principal method of controlling hospital costs. In our review of the legislative histories of the New York CON laws and the federal statutes that adopted the CON approach, we were surprised to discover that no respectable voice within the hospital or public health establishments had spoken against regional planning or hospital construction controls on any grounds; no recognized authority in hospital matters, so far as we could determine, pointed out that planning and controlling construction would tend to concentrate the hospital industry and to accelerate the rise in hospital costs.

Such unanimity is unusual, particularly within an industry as heterogeneous as the hospital industry. That the consensus included not only the leadership of the hospital industry itself, but also government and university-based public health authorities, suggested to us that there must be some hidden explanation. In the biographies of the persons principally responsible for promoting regional planning and CON we found evidence of close informal ties among institutions that were formally independent of one another. The careers of voluntary hospital and public health leaders showed a pattern of movement within voluntary hospital management, voluntary hospital associations, the Blue Cross, and university schools of public health, suggesting that these institutions share a common outlook and have a common pool of high-level officials.

The concerted behavior of a large and diverse group of hospital and public health officials in promoting regional planning and CON cannot be understood, however, as the outcome of the career patterns of a few chief executives. Underlying both the career patterns and the unanimous support for regional planning is the fact that the voluntary hospital and public health establishments share a common ideology. The cornerstone of that ideology is the idea of a planned regional health care system with the large teaching hospital at its center, and with all other elements of the health care system as satellites. This concept of the health care system was first developed by

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result of good planning as we strive to make comprehensive health care available to larger numbers of people.

Rosenfeld, *Areawide Planning Controls Costs*, 46 *HOSPITALS*, Feb. 1, 1972, at 40.

the voluntary hospital establishment. It was legitimized and enshrined in federal policy by the original Hill-Burton Act of 1946, which was the product of a close collaboration between the American Hospital Association and the United States Public Health Service. From that time forward health planners, whether in the public or the private sector, have been educated in the belief that the entire health care system should be centered on the large teaching hospital.

A clear focus on the commitment of the public health and hospital establishments to the large teaching hospital and their belief in rationalizing the health care system through community-based planning allows us to understand the ideas and institutions that have produced our present system of hospital regulation. It can also help us to understand the structure and behavior of the hospital industry and can illuminate current controversies over health care policy.

What follows is a narrative account of the development of regional planning and certificate-of-need legislation. As part of that story, we trace the evolution of the Blue Cross, explain its central role in the voluntary hospital and health insurance industries, and show how the voluntary hospital and public health establishments came to its rescue in the controversy over rising Blue Cross rates in the late 1950s. We offer a brief summary of our findings at the outset to make the Article more accessible to the general reader; at the close of the text we discuss Roemer's Law, the economic theory used to justify CON legislation, and the system of voluntary sector self regulation that CON complements.

## I. SUMMARY: THE FORGOTTEN ORIGINS OF REGIONAL PLANNING AND CERTIFICATE-OF-NEED

Certificate-of-need regulation was invented in the late 1950s, at a time when the voluntary hospitals and the Blue Cross were under attack on a variety of fronts: several state insurance commissioners and legislatures, stimulated by public concern over rising Blue Cross rates, were threatening to hold down hospital costs by regulating Blue Cross rates and reimbursement policies; the cost of health care for the aged had pushed compulsory government health insurance, or "socialized medicine," as its opponents called it, back onto the national agenda; and the Blue Cross was losing ground to the commercial insurance companies, which had begun to offer health and hospitalization insurance. At the same time, the explosive growth of metropolitan areas and the spread of health insurance were stimulating new hospital construction both by voluntary hospitals and, more ominously from the point of view of the hospital and public health

establishments, by proprietary hospitals. Many of these new hospitals were small, and the smallest proprietaries functioned as extensions of physicians' offices. The proliferation of hospitals was of great concern, not only to the existing hospitals, but also to the United States Public Health Service and state hospital planning agencies, to whom the federal Hill-Burton Act had given responsibility for planning coordinated regionalized hospital networks.

Uncoordinated growth threatened to create many small and medium-sized institutions; the public health planners preferred to develop the hospital system around the few large teaching hospitals that were the centers of elite, scientifically sophisticated, medical practice. At the very time when advancing technology was enhancing the role of large teaching hospitals in medical research and education, middle-class population and private resources were migrating away from the core cities, in which most of the elite hospitals were located. Preserving these institutions and maintaining the concept of regional centralization of resources, to which the health planners were committed, required that small hospital development be stifled and that construction of adequately sized hospitals in the growing suburban areas (which was inevitable) be controlled. Otherwise, unnecessary competition for patients and resources would injure the core institutions. Officials thought they could meet their objectives both by preventing the construction of hospitals that failed to conform to a regional plan and by encouraging the hospitals within a region to use their facilities efficiently through collective action under the sponsorship of regional planning agencies. The public health planning establishment thus collaborated with the voluntary hospitals in presenting to the public the idea of regional planning and controls on hospital construction as the cornerstone of public policy toward hospitals. They also agreed that the public desired high-quality care and would accept rising costs if the hospitals could demonstrate that they were serving community needs and were managed efficiently.

It was the Blue Cross financial crisis, however, that stimulated adoption of the first state certificate-of-need legislation. As hospital costs rose in the 1950s, health insurance costs rose with them. In the major eastern and midwestern states where Blue Cross dominated the health insurance market, rising hospital costs translated directly into rising Blue Cross rates. By the late 1950s the major Blue Cross plans were forced almost annually to ask state insurance commissioners for large rate increases, generating political controversy over whether the close relationship between the Blue Cross and the hospi-

tals was preventing the Blue Cross from protecting the interests of its subscribers. Some state insurance commissioners and legislatures threatened to use their authority over Blue Cross rates and reimbursement policies to control hospital costs, and through cost control to influence the nature of hospital-based medical care. There was also considerable political interest in amending Blue Cross enabling statutes to require broader community and subscriber representation on Blue Cross plan governing boards.

The Blue Cross was anxious to avoid further embroilment with the insurance commissioners and to restore public confidence in itself and in the voluntary hospitals. Its own survival as an organization depended on its ability to keep hospital care affordable for the broad middle group of citizens; however, its symbiosis with the hospitals disabled it from engaging in arm's-length bargaining with them over costs, and Blue Cross leaders shared the hospitals' belief that containing costs would compromise the quality of care.

Some entire cost centers could be eliminated, however, without compromising elite hospital values: if the Blue Cross could rid itself of responsibility for reimbursing small hospitals, and if the voluntary hospital establishment would discipline itself to build new facilities only if they were actually necessary, then the community's total hospital bill as reflected in Blue Cross rates could be justified by the standards of elite medical practice and by community need. With this in mind, the Blue Cross became a primary proponent of regional planning and hospital construction controls. Of course, eliminating smaller hospitals did not mean that there would be actual savings to the Blue Cross; eliminating smaller hospitals would only provide space for larger and more expensive hospitals to grow. Hospital costs and therefore Blue Cross rates could be expected to increase even more rapidly if all institutions conformed to elite standards. The function of the CON program from the Blue Cross perspective was to legitimize these trends and to avoid criticism of itself and the hospitals based on uninformed allegations of waste.

The leaders of the voluntary hospital establishment were anxious to preserve the legitimacy of the Blue Cross. The Blue Cross and the system of private health insurance that it anchored were the hospitals' bulwark against government-sponsored health insurance, which would end the institutional autonomy of the voluntary hospitals and erode the quality of elite medical practice and teaching by equalizing resources among many different types of institutions. Federal health insurance for the aged and the poor was already becoming politically achievable, largely as a result of rising hospital costs; a general loss

of faith in the voluntary health insurance system could turn into a political stampede toward compulsory government health insurance. The Blue Cross and the hospitals thus pulled together in the crisis of the late 1950s as it became clear that voluntary hospitals and voluntary health insurance would survive or perish together.

Regional planning and hospital construction controls had originally been invented by the voluntary hospital establishment to guide private fundraising activities at a time when hospitals were still primarily charitable institutions. By the 1950s, however, the spread of health insurance had produced a strong consumer demand for services over a wide range of quality and rich incentives for entry into the hospital industry. The program of regional planning and construction controls that the hospital and public health establishments wished to enforce amounted to a cartel dedicated to controlling entry and maintaining standards. The most desirable cartel manager from the point of view of the hospitals was the Blue Cross, which could use its market power to restrain entry by unwanted new hospitals and to set minimum standards in states where it was the dominant health insurer. One of the first states to undertake the program was Michigan, where the Blue Cross was dominant in the health insurance market and had strong support from business and labor. In collaboration with the voluntary hospitals and the public health establishment, the Michigan Blue Cross in 1960 began refusing reimbursement for the capital costs of new hospitals whose construction could not be justified by public need and setting minimum standards for hospitals seeking Blue Cross participating status. State government agencies endorsed the closing of existing small hospitals and agreed that no additional ones would be built.

As the hospital and public health establishments promoted regional planning and hospital construction controls throughout the 1960s, these programs came to be identified with the objective of controlling hospital costs, on the theory that a properly coordinated hospital system would eliminate unnecessary hospital beds and unnecessary duplication of services, equipment, and facilities. The emphasis on planning and construction controls as a potential method of cost control became pronounced when the voluntary hospitals and the public health establishments, unable to use the Blue Cross as the cartel manager, were forced to turn to the government for assistance in controlling hospital expansion.

New York was the first state to adopt legislation requiring mandatory regional planning and certification-of-need for construction of hospital facilities. In New York, as in other states with large



Blue Cross plans, escalating hospital costs had forced the Blue Cross to seek frequent and large rate increases, giving rise to public controversy over the viability and legitimacy of the Blue Cross. Center city resources were draining away toward the suburbs, particularly in the New York City metropolitan area, creating financial difficulties for the city's large voluntary hospitals, which were some of the finest in the nation. Operating in a far more heterogeneous and contentious environment than did the Michigan Blue Cross, however, the eight Blue Cross plans in New York State could not control hospital construction solely through their own market power; they needed to enlist the licensing power of the state government, which had its own interest in preserving the voluntary hospitals of New York City.

New York's certificate-of-need legislation, adopted in 1964, was intended to be friendly regulation: it had originally been proposed by the public health and voluntary hospital establishments; the state regulatory agencies that gained licensing power under the legislation were expected to concur in the recommendations of regional planning agencies whose memberships were to consist mainly of representatives of hospitals, medical societies, and public health interests, with some participation by business, labor, and local government. The role of state authority was to put "teeth" into the decisions of those agencies, which were designed to carry on the tradition of voluntary sector self-governance.

The New York City Blue Cross was a major proponent of mandatory planning and CON. It insisted with increasing urgency that the legislation was needed to keep Blue Cross rates down. Since CON was presented as a solution to the problem of rising Blue Cross rates, it was also characterized politically as a solution to the problem of rising hospital costs: public concern had centered on the threat of uncontrollably rising costs, and any "solutions" involving the exercise of public authority had to be described as methods of warding off that threat.

The tenuousness of the linkage between certificate-of-need and cost control was never brought to public attention. All of the experts on hospital matters supported CON while earlier proposals for more definitive forms of cost containment withered. The New York State Insurance Commissioner, like his counterparts in other states, had threatened to control hospital costs by regulating Blue Cross reimbursement policy; that suggestion was buried in the unanimity of opinion among hospital experts that state supervision of hospitals should be lodged primarily in the state health department, which was part of the public health establishment. Passage of CON legisla-

tion had the practical effect of transferring principal responsibility for protecting the public interest in affordable hospital care from the cost-conscious insurance commissioner to public health officials who shared the hospitals' belief in the primacy of quality. Neither the Blue Cross nor the hospitals nor the public health officials themselves in New York had an interest in dispelling the impression that CON would help to control costs, if creating that impression was necessary to advance the program with the legislature. The misunderstandings created by the Blue Cross's urgent exhortations thus went uncorrected.

This unanimity among hospitals and public health experts is central to an understanding of why regional planning and CON was later adopted without significant inquiry by numerous state governments and promoted by the federal government as a primary response to rising costs. The voluntary hospitals, the public health establishments, and the Blue Cross had a virtual monopoly on credible discourse about hospital matters during the 1950s and 1960s. They stood for the public interest, nonprofit status, community service, and quality medical practice. The interests opposed to regional planning and CON, by contrast, were principally medical societies representing physicians in private practice and, worse, the small hospitals, many of them either unaccredited or proprietary or both. They could be thought to represent medical mediocrity, private advantage, and even greed, and their opposition to regionalization could be characterized as a selfish refusal to participate in responsible collective self-government in the service of their communities.

Their point of view was also politically unfashionable: they advocated free competition in the medical marketplace and the autonomy of the individual physician at a time when the dominant current of public policy was running the other way. Regionalized health planning was only one of a number of contemporary commitments to greater discipline in the use of public resources. Regional planning for land use, sewage treatment, schools, housing, and transportation was being undertaken in order to counteract urban sprawl. Large size was considered a positive attribute in institutions, and it still connoted efficient centralization of resources. Medical free enterprise did not make many converts in this environment.

Advocates of regional hospital planning and certificate-of-need had another great advantage over critics: they presented a comprehensive idea about the teaching and practice of medicine and the organization of health care resources. Critics, by contrast, never developed an alternative model of medical services organization that

might make noncentralized, competitive health care seem to serve the public interest. Competition itself was not a plausible value because the medical marketplace was regarded as a conspicuous example of market failure. Community-based planning with citizen participation appealed to the general enthusiasm for citizen involvement that marked many programs developed in the 1960s. Finally, regional planning and CON regulation represented an attractive solution to public officials' need to "do something" about political controversy over hospital costs, even though the program promised to contain the controversy rather than the costs.

Government regulation of hospital costs was not obviously preferable to CON and in any event would have been fought bitterly by the voluntary hospital establishment, forcing politicians into confrontations with local community leaders who served on the governing boards of the voluntary hospitals. CON had the advantage of being an expression of support for the voluntary hospitals rather than an attempt to subjugate them. It preserved the traditional division of responsibility between the public and the voluntary sectors in health care matters. It also held out the hope that the voluntary hospitals and the Blue Cross, with only a little bit of help from the government, could keep the health care industry respectable, contain controversy over costs, and forestall demands for more challenging forms of government action. Certificate-of-need was thus a convenient political response to a problem that had no clearly right answer.

From the point of view of the voluntary hospital establishment, however, CON represented a loss of autonomy, however modest, and a compromise with demands for even greater government intervention. It was an essentially defensive program. Experience under the New York CON process demonstrated, however, that government regulation, if unavoidable, could be designed to reinforce and legitimize elite voluntary hospital decisionmaking.

Four years elapsed between passage of the New York legislation and enactment of the next state CON law. During that time the voluntary hospital and public health establishments continued to collaborate in promoting regional health planning, which by the mid-1960s was intended to encompass comprehensive planning for services as well as facilities. Meanwhile, passage of federal Medicare and Medicaid legislation in 1965 had made governments at all levels major purchasers of health care services; escalating hospital costs precipitated a near crisis in public finance. It was clear that if the hospitals did not regulate themselves, governments were prepared to

step in. Voluntary hospitals and public health officials again looked to state-enforced mandatory regional planning and hospital construction controls as a way of avoiding direct government action to control costs.

This was the atmosphere in which CON legislation proliferated. Between 1969 and 1972, twenty states adopted various forms of CON regulation, typically at the urging of the voluntary hospitals, the public health establishment, and the Blue Cross, and always on the premise that it would help to contain costs. In 1972 the federal government began to allow states to refuse Medicare and Medicaid reimbursement to hospitals for the capital costs of new construction that had not been certified as required by the public need. In the Health Resources Planning and Development Act of 1974, the federal government required that states adopt CON legislation as a condition of the receipt of certain federal grants. Federal promotion of CON complemented the regional health planning movement that it had fostered throughout the 1960s, because state legislation could assign CON functions to already existing comprehensive health planning agencies.

These developments occurred before the consequences of CON regulation were understood. When economists in the mid-1970s investigated the consequences of early CON legislation they discovered that enactment of the program had either no effect on cost trends or a slightly adverse influence by accelerating the trend toward fewer but larger, more capital-intensive, and therefore more expensive hospitals. The planning agencies themselves displayed characteristics often noticed in other regulatory agencies that control entry into an industry by potential competitors: they tended to discourage construction of new hospitals in favor of allowing expansion of existing ones, to allow the "planning process" to deteriorate into political bargaining, to maintain close ties with the hospital associations, and generally to behave in ways that have given rise to the notion of regulatory agency "capture."

Once the mythologies of cost control are laid aside, however, it becomes clear that this is exactly what was intended. Regional planning was intended to be an act of collective self-governance among largely autonomous institutions; certificate-of-need was intended to promote regional concentration of hospital resources and to ensure that all facilities met high standards. These central objectives have been largely achieved. Indeed, the entire joint effort of the public health and voluntary hospital establishment, beginning with their collaboration in enacting the Hill-Burton Act of 1946, must be seen

as a public policy with remarkable intellectual consistency and political durability. The idea that everyone should have access in time of need to necessary medical resources without constraints based on individual ability to pay is linked powerfully to the idea of equal citizenship; belief in scientific and technological progress continues to be the cornerstone of faith in modern medicine; and trust in elite hospital and medical institutions, while eroding, is quite high. The present institutional structure has served its principal purposes and has been broadly consonant with the values of the times during which it has developed; as ideas about what constitutes quality medical care and the role of the hospital as an institution change over time, perhaps an equally coherent, though different, constellation of public values will emerge.

## II. SYMBIOSIS AND AMBIVALENCE: THE BLUE CROSS AND THE HOSPITALS

The modern hospital system is founded on voluntary prepayment of hospital costs through private health insurance. Voluntary health insurance has made it possible for American society to move substantially toward realizing its two major aspirations with respect to medical care: (1) that every person should have access in time of need to high quality medical care without barriers based on individual ability to pay; and (2) that all care should be based on the most advanced scientific methods of treatment as determined by university medical schools and teaching hospitals. Health insurance has fueled and financed the reciprocal demands of physicians for fine hospitals and of hospital administrators for institutional prestige in the form of medical school affiliations and medical staffs dominated by specialists. The availability of sophisticated hospital practice facilities in turn has made it feasible for medical schools, with the active support of private foundations and the federal government,<sup>4</sup> to

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4. Private philanthropy dominated medical education and research until 1940. Following publication of the Flexner Report in 1910 the General Education Board, one of the Rockefeller organizations, actively promoted the conversion of medical training into university-based scientific medical education with fulltime faculty and close relationships with academic science departments. The Rockefeller group of organizations and other private foundations established research laboratories, made endowment grants to medical schools and schools of public health, provided training for research through individual fellowships and institutional grants, and aided specific research projects. See Rosen, *Patterns of Health Research in the United States, 1900-1960*, 39 BULL. HIST. MED. 201, 212-16 (1965); R. FOSDICK, *ADVENTURE IN GIVING* 140-87 (1962). Private philanthropy was also the principal source of capital for hospital construction until the mid-1960s. The federal government became dominant in health research and education funding after World War II, principally through the Public Health Service and the National Institutes of Health. These agencies stressed biomedical research and generally strengthened the relationships between science and medicine. By 1973, governments at all levels were outspending private philanthropy in medical research and health facility

promote scientific training and research and to train young physicians for careers as specialists.

The Blue Cross laid the groundwork for these developments: it pioneered voluntary health insurance, which has provided a stable source of revenue for the hospitals, and it has made health insurance protection available to a broad middle range of citizens, thereby averting compulsory, universal, government health insurance. The origins of the Blue Cross lie, however, not in aspiration but in desperation. The Blue Cross, like so many other systems of social insurance, was a response to the strains and opportunities created by the Depression.

As it entered the Depression, the voluntary hospital system was principally a creation of the 1920s, which had seen a flowering of charitable giving as the wealthy demonstrated their civic responsibility by endowing civic and cultural enterprises. Between 1921 and 1931 hospital bed capacity, funded primarily by private philanthropy, increased by fifty-five percent.<sup>5</sup> Prosperity revealed, however, the inherent instability of hospital finances. Increases in hospital capacity only increased the magnitude of the task of raising operating funds, which had to be recovered through a combination of patient fees and annual charitable solicitations.<sup>6</sup> The cost of hospital care was beyond the reach of many citizens; occupancy rates in the expanded hospital system began to decline. By 1928 occupancy of the voluntary hospitals in New York City had dropped to fifty percent while the public hospitals, to which patients could go for charity care, had filled to capacity.<sup>7</sup>

The advent of the Depression threatened to sink the voluntary hospital sector altogether as private philanthropy dried up and personal incomes fell. As early as 1930 some voluntary hospitals in

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construction by a ratio of almost three to one. *See generally* Terenzio, *A Survey of the History and Current Outlook of Philanthropy as a Source of Capital for the Needs of the Health Care Field*, in *HEALTH CARE CAPITAL: COMPETITION AND CONTROL* 239 (G. MacLeod & M. Perlman eds. 1978). The characteristics of medical schools and medical school graduates have been influenced heavily by the preferences of the philanthropic and government sectors for scientifically trained specialists. *See* Hall & Lindsay, *Medical Schools: Producers of What? Sellers to Whom?*, 23 *J. LAW & ECON.* 55 (1980); Rosen, *supra* at 201, 212-16; Swain, *The Rise of a Research Empire: NIH, 1930-1950*, 138 *SCIENCE* 1233-37 (1962); Blendon, *The Changing Role of Philanthropy in Health Affairs*, 292 *NEW ENG. J. MED.* 946 (1975); Drew, *The Health Syndicate*, *ATLANTIC MONTHLY*, Dec. 1967, at 75-82.

5. BLUE CROSS COMMISSION, *THE HISTORY OF BLUE CROSS 1929-1955*, at 2 (undated; evidence suggests preparation in 1955-1956).

6. For a contemporary discussion of this dynamic see Vladeck, *Why Non-Profits Go Broke*, *PUB. INTEREST*, Winter 1976, at 86.

7. *See* BLUE CROSS COMMISSION, *supra* note 5, at 2-3.

New York were on the verge of closing their doors;<sup>8</sup> occupancy rates and income were low in voluntary hospitals all around the country. The problem was that patients could not afford the cost of illnesses when they occurred; the solution was prepayment in small installments, and it was discovered not in New York City, the traditional center of leadership in hospital matters, but at Baylor University in Dallas, Texas.

The father of hospitalization insurance was Justin F. Kimball, who in 1929 was serving as the executive vice-president of Baylor University and was in charge of the Dallas medical units of the university. Dr. Kimball had been superintendant of the Dallas public schools during the influenza epidemic of 1918-1919. During that epidemic teachers who fell too ill to work were reduced to half pay for two weeks and then dropped from the payroll. Thinking this system unduly harsh, Dr. Kimball devised a scheme, called the Sick Benefit Fund, under which each teacher might contribute one dollar per month into a common fund in exchange for a right to draw six dollars income for each day's absence from work due to illness.<sup>9</sup>

Dr. Kimball went to Baylor University in 1929. As he watched the financial troubles of the university hospital deepen, he discovered that many unpaid bills belonged to teachers covered by the Sick Benefit Fund.<sup>10</sup> Building on the design of the Fund, he offered the teachers an additional plan for hospitalization, under which they would receive a guarantee of up to twenty-one days of hospital care and a one-third discount on the next 344 days (except in times of epidemic) in return for a prepayment of fifty cents per month. The plan was adopted immediately by the teachers, then by other employee groups in the Dallas area. It was hailed as a great success.<sup>11</sup>

During the next decade hospitalization plans modeled on the Baylor Plan were adopted around the country under the symbol of the Blue Cross. It is worth pausing, therefore, to examine more closely the principal features of the Baylor Plan, which set the pattern that has endured for over half a century. The plan was narrowly focused on two objectives: (1) to increase the flow and reliability of hospital revenues; and (2) to increase the teachers' ability to use and pay for hospital services in time of need, which in 1929 meant in time of serious illness. It did not finance services provided by other health care institutions or individual professionals, includ-

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8. See J. HIRSH, SATURDAY, SUNDAY AND EVERYDAY 54 (1954).

9. See BLUE CROSS COMMISSION, *supra* note 5, at 5-6.

10. See R. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 10 (1963).

11. See BLUE CROSS COMMISSION, *supra* note 5, at 6-8.

ing physicians, unless their services were part of the basic hospital charge.<sup>12</sup> The plan was based on the traditional notion that high-quality medical care should be available without financial barrier when needed, and thus featured no deductible or coinsurance and no waiting period before benefits would commence. Its shallow coverage (twenty-one days) was designed to deal with ordinary, not extraordinary, requirements for hospitalization.

The premium was set by contract between the hospital and the teachers' association; it reflected both the infant status of hospital cost accounting and the fundamental ambivalence that has plagued the Blue Cross in its efforts to protect the interests of both its subscribers and the hospitals. In reviewing the books of the Sick Benefit Fund, Dr. Kimball had discovered that school teachers had been paying, on the average, only about fifteen cents per month for hospital bills. "And I figured they had used at least twice as much hospitalization as they paid for, *so to make it safe*, I made a tentative fee of fifty cents a month" (emphasis supplied).<sup>13</sup> Even with the apparently generous margin provided by Dr. Kimball's calculations, the difficulty of predicting hospital utilization and cost appeared immediately: the plan showed a \$900 loss on 1500 members after its first year of operation.<sup>14</sup> It was nonetheless hailed as a success, and the plan was immediately copied by two other hospitals operating in the Dallas area.

Although Dr. Kimball's plan at Baylor was the first to employ hospital prepayment, the idea itself had occurred more or less simultaneously to a number of people who were struggling with problems of hospital financing. The central actor in what was to become the Blue Cross movement was C. Rufus Rorem of the Julius Rosenwald Fund, a Chicago charitable foundation that made a practice of giving grants for self-help projects. Dr. Rorem had been an assistant professor of accounting at the University of Chicago Business School and had studied capital formation in the hospital sector. His work led him to the question of hospital prepayment.<sup>15</sup>

Dr. Rorem viewed hospital prepayment plans principally as a way of solving the problems of patients, not of the hospitals themselves. Hospital prepayment promised to insulate people against the

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12. Dr. Kimball did not consult the medical staff of the university hospital before placing the plan in effect.

13. See BLUE CROSS COMMISSION, *supra* note 5, at 7.

14. See *id.* at 8.

15. Unless otherwise indicated, information concerning the development of the Blue Cross plans in the 1930s is based primarily on O. ANDERSON, BLUE CROSS SINCE 1929: ACCOUNTABILITY AND THE PUBLIC TRUST 29-44 (1975).



rising and unpredictable costs of care. By eliminating conflict between hospitals and patients at the time of payment for services, it also promised to promote community confidence in hospitals. Rorem began to promote the idea of prepayment through both published articles and personal contacts within the American Hospital Association, whose Committee on Uniform Hospital Accounting he chaired in the early 1930s. The Baylor Plan quickly attracted the attention of Dr. Rorem, who arranged to have it discussed at the 1931 AHA convention.

In 1932, Frank Van Dyk, the Executive Secretary of the Hospital Council of Essex County, New Jersey, was faced with a mountain of uncollectible accounts at the seventeen hospitals in Essex County. He remembered having heard something about prepayment at the 1931 convention, and he went to Dallas to see if he could learn something from the Baylor Plan. Van Dyk was impressed with the prepayment idea. In addition, he saw his own organization as the vehicle for avoiding the potential problem of multiple plans, which were inconvenient for patients whose preferred physicians did not have admitting privileges at the hospitals to whose plans the patients belonged. Van Dyk developed the idea for a single plan sponsored by his hospital council on behalf of all seventeen hospitals. He first approached private commercial insurers to see if they could provide the service; they responded that health insurance would be too risky because of the lack of actuarial/statistical information on hospital utilization. The hospitals were thus forced to create their own system: the Essex County Hospital Council issued its first contract in January 1933, with rates of ten dollars per year for twenty-one days of hospital care (excluding maternity care).<sup>16</sup>

The Essex County plan added the critical element of county-wide participation by all hospitals to the basic insurance design established by Baylor, which it otherwise copied virtually in its entirety. The Essex County plan thus pointed the way for a regional approach to hospital insurance, reinforcing the newly established pattern of hospital cooperation through regional and local hospital councils. These councils, which engaged principally in trade association activities, were by the 1930s already becoming the forum for joint and collective action on the part of member hospitals.<sup>17</sup> They were to become the institutional parents of the Blue Cross plans.

Following the regionalized model developed in Essex County, a

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16. *See id.* at 34-35; BLUE CROSS COMMISSION, *supra* note 5, at 8-11.

17. *See, e.g.*, GREATER CLEVELAND HOSPITAL ASSOCIATION, A HISTORY OF THE GREATER CLEVELAND HOSPITAL ASSOCIATION 1916-1917 (1976).

number of local plans were created in scattered parts of the country. The name and symbol of the Blue Cross were developed in 1934 by the founder of the St. Paul, Minnesota plan, who offered it to Dr. Rorem for national use.<sup>18</sup> By 1935 the hospital service benefit plans had a standard program design and organizational format, an attractive symbol, and nearly a quarter of a million subscribers in fifty cities. Its supporters called themselves the Blue Cross movement.

Blue Cross was clearly an idea whose time had come. It was a community-based scheme for a form of social insurance that virtually everyone agreed was beneficial, developing at a time when even compulsory government income security measures were gaining popular support. It was consistent with the tradition of voluntary community self-help. Moreover, the Blue Cross idea was eminently portable. It required only a willing hospital and a willing group of subscribers. Because the plans covered only hospital charges, the hospitals did not need the consent of other providers (such as physicians, who bill separately even for services rendered within a hospital) to set up the program. That Blue Cross could be controlled by the hospitals themselves allayed fears about oversight and intervention by outsiders. Finally, the Blue Cross idea took hold during the bleakest days of the Depression, when hospital administrators and trustees were willing to try almost any technique that might keep them above water, even though to some of them Blue Cross looked like private socialism.

Notwithstanding the ripeness of the Blue Cross idea, events might have taken quite a different turn without the inspired leadership of a few people, particularly Dr. Rorem. Originally, the hospitals themselves were not enthusiastic about the prepaid insurance idea; they had to be shown that collecting only pennies a day from thousands of people could in fact solve their financial problems. The challenge for Dr. Rorem and his pioneering colleagues was to make the successes of the early experiments known widely and to provide assistance to various communities in organizing hospital service plans. In 1934, at the urging of Dr. Rorem, the board of trustees of the American Hospital Association formally "encouraged" the development of nonprofit hospital service organizations and set "standards" that ratified the most attractive, public-service features of the plans already in existence.<sup>19</sup>

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18. See O. ANDERSON, *supra* note 15, at 35-36; BLUE CROSS COMMISSION, *supra* note 5, at 12-15.

19. The standards are set out in full in Rorem, *Enabling Legislation for Non-Profit Hospital Plans*, 6 LAW & CONTEMP. PROB. 528, 543-44 (1939).

Meanwhile, however, the growth of multi-hospital plans had generated an important legal issue in several states: did the hospital service plans constitute the business of insurance within the meaning of existing state regulatory statutes? When groups of hospitals in New York and Ohio attempted to organize plans in 1933, they were advised by state authorities that they would have to create either a stock or a mutual insurance company. The hospitals were not in a position to raise money to meet the capital requirements imposed on insurance companies; moreover, those requirements were inappropriate for the hospital service plans, which offered their subscribers service guarantees by the hospitals themselves rather than cash indemnification from a common fund. In any event, the selling of insurance is widely regarded as a commercial activity, and the hospitals were committed to the symbolism of nonprofit status. The hospital service plans thus needed to be exempted from the insurance laws and recognized as distinct legal entities. By this time Dr. Rorem was already promoting the idea of special enabling legislation for the plans. In New York, the leaders of hospital, medical, and lay groups fostered the passage of the first enabling act, which set the pattern for the nation.

Under the 1934 New York act,<sup>20</sup> nonprofit hospital service associations were allowed to organize with the approval of both the Insurance and Welfare Departments of the state. Members of the boards of directors were required to be representatives of the contracting hospitals. The plans were exempted from most of the insurance laws; however, they were subject to the rate approval, reporting, and examination requirements that applied to commercial insurance companies. In addition, the Superintendent of Insurance had authority to review rates of reimbursement to the contracting hospitals. The plans were exempted from all state and local taxes except those on real and personal property.

The New York enabling act was followed quickly by similar legislation in California (1934), Illinois (1935), and Pennsylvania (1937). The statutes set into state law the most prominent features of the hospital service plans: they were authorized to insure against only the costs of hospitalization, and they were to be controlled by the hospitals themselves. The enabling acts expressed official state approval of hospital control of the plans and confirmed the hospitals' representations to the public that the plans were special community-based organizations, not commercial insurance companies. Blue

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20. 1934 N.Y. Laws, c. 595 (current version, including 1939 amendment, at N.Y. INS. LAW §§ 250-60 (McKinney 1980)). See also Rorem, *supra* note 19.

Cross was designed for social service, not for profit. State legislation gave the hospital service plans symbolic reinforcement and their own legal space in which to grow.<sup>21</sup>

The growth was spectacular. The Associated Hospital Service of New York, with ninety-three hospitals participating, enrolled its first members in May 1935; within a year it was serving 210,000 members and paying a half million dollars per year to the hospitals. By 1938 it had become a "stabilizing force in the matter of hospital income."<sup>22</sup> It quickly established itself as the largest of the hospital service plans and became a pacesetter in developing standards and policy.

At the same time that the Blue Cross movement was gaining momentum in the early 1930s, the Roosevelt Administration was attempting to include a national health insurance component in the Social Security Act.<sup>23</sup> That effort failed in the face of strong opposition by organized medicine; however, some form of protection against the economic hazards of major illness was demanded by a public that was growing accustomed to the idea of social insurance. As the prospect of compulsory national health insurance receded, it became apparent that Blue Cross plans offered the only feasible means of providing hospital insurance to the majority of the American people. Dr. Rorem began to think in terms of a national organization and a national system. The Rosenwald Fund, however, with which Dr. Rorem was still affiliated, was terminating its activities in the medical field. The Fund gave Dr. Rorem custody of \$100,000 with directions to find another nonprofit agency that could serve as his organizational home. The Twentieth Century Fund and the Community Chest and Councils of America both refused his overtures; he was then driven to affiliate with the American Hospital Association.

The tension between the idea of the Blue Cross as a representative of the interests of its subscribers and the Blue Cross as the financing arm of the hospitals now became a source of real institutional discomfort. The AHA leapt at the opportunity to receive the Rosenwald funds; however, Dr. Rorem was determined not to allow the Blue Cross movement to become an arm of the hospitals' trade association. He therefore created a body known as the Commission on Hospital Service under the sponsorship of the AHA, but on which the AHA itself was not represented. As Rorem later said in an inter-

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21. See generally O. ANDERSON, STATE ENABLING LEGISLATION FOR NON-PROFIT HOSPITAL AND MEDICAL PLANS (1944).

22. See J. HIRSH, *supra* note 8, at 61-63.

23. See E. WHITE, THE DEVELOPMENT OF THE SOCIAL SECURITY ACT 173-89 (1962).

view, "We were a de facto self-determining organization. We would report to the trustees when we thought there was something interesting to report, not because we thought it was any of their business."<sup>24</sup> He selected the first members of the Committee for their records of public awareness, and for his confidence that "they could be relied on to keep hospital influence in its proper bounds."<sup>25</sup> Nonetheless, three of the four members of the first Commission were present or past presidents of the AHA, and all four were or had been administrators or trustees of major hospitals that were important elements of the hospital establishment.<sup>26</sup>

Through the Commission, Dr. Rorem advocated passage of enabling legislation in the various states, assisted in the formation of Blue Cross plans, set standards for the use of the Blue Cross emblem by the various plans, and promoted sound administrative practices. In 1930, the Commission published a model law that incorporated the best features of existing enabling legislation.<sup>27</sup> Dr. Rorem worked closely with various plans to obtain passage of the legislation in several states.<sup>28</sup>

The social service orientation of the Blue Cross pioneers was unquestionably genuine;<sup>29</sup> indeed, in later interviews several of them have emphasized the difficulty they faced in persuading the hospitals to assume the risks associated with a guaranteed service benefit plan. They emphasized the benefit to the public of good hospital service in time of need. Yet many of the administrators of participating hospitals and even Blue Cross plan directors viewed Blue Cross principally as a source of badly needed revenues for the voluntary

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24. O. ANDERSON, *supra* note 15, at 38.

25. *Id.* at 39.

26. *See id.* at 37-39.

27. *See* Rorem, *supra* note 19, at 542-43 app.

28. *See* O. ANDERSON, *supra* note 15, at 40.

29. Anderson notes that the four principal Blue Cross pioneers who laid the groundwork for Blue Cross during the 1930s (Van Dyk, Rorem, Van Steenwyk [who designed the symbol], and Mannix [Michigan's first director]) were between the ages of 25 and 36 when they began, and that all "embodied the old fashioned virtues of hard work, enlightened self-interest, enthusiasm, imagination, pragmatism, and dedication to the public interest." None of them was trained in medicine or had formal schooling in hospital administration, and none of them came from a professional family. *See id.* at 29-30.

Most of the early Blue Cross leaders continued to be active and influential in hospital and Blue Cross affairs for several more decades. Frank Van Dyk was instrumental in developing the New York Blue Cross organization and later joined the faculty of the Columbia University School of Public Health and Administrative Medicine, where he helped design New York's certificate-of-need laws in the early 1960s. C. Rufus Rorem served for many years as the Executive Director of the Allegheny County (Pa.) Hospital Planning Council; in 1960, when CON legislation was being formulated in New York, he went as a consultant to the Southern New York Hospital Review and Planning Council.

hospitals and as a bastion against governmental health insurance. The source of tension in the relationship would come to be the reimbursement policy. Would the Blue Cross behave as an agent of its subscribers in arm's-length negotiations with the hospitals, and attempt to hold down hospital prices and therefore rates for its subscribers? Or would the Blue Cross act as the agent of the hospitals, paying for any service the hospitals wished to provide at any price they wished to charge, and collect from Blue Cross subscribers sufficient revenues to cover those charges? Hospital control of Blue Cross plans implied that the Blue Cross was the agent of the hospitals; the public service rhetoric of the Blue Cross movement and the nonprofit form of the plans themselves suggested that the principal purpose of the Blue Cross was to make health care affordable to the public.<sup>30</sup> This conflict, latent in the beginning, became more pronounced as the growth of private health insurance programs made the hospitals more dependent on third-party payment. The Blue Cross adopted the policy of full-cost retrospective reimbursement under which it rarely questioned hospital costs; the large voluntary

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30. The mystique of being "nonprofit" was critical to the public image, and perhaps also the self-image of the early Blue Cross plans. Nonprofit status enabled the hospital service plans to derive some of their initial financing in the form of grants and loans from foundations, community chests, and the hospitals themselves. *See id.* at 41; J. HIRSH, *supra* note 8, at 62. The nonprofit status of the hospital service plans was also consistent with the status and image of the participating hospitals, most of which were private nonprofit or governmental entities.

As a legal matter, of course, nonprofit status means only that any surplus developed by the operation is not distributed to shareholders in the form of dividends. From this point of view, it is not unrealistic to characterize mutual insurance companies as nonprofit, since the only shareholders are the policyholders, to whom accrues any surplus. The Blue Cross pioneers meant something more, however, when they insisted that hospital service plans be nonprofit: they meant to project the image of the plans as community-sponsored institutions apart from the world of commerce. The primary practice that justified this characterization was the practice of "community rating." Community rating was doomed by the rise of competition; however, and Blue Cross plans moved rapidly toward experience rating as commercial insurers entered the market. *See* R. EILERS, *supra* note 10, at 210-24 and text at notes 32-33 *infra*.

Another aspect of Blue Cross that was thought to be uniquely community-service oriented was that the contracting hospitals were legally bound to provide service to the subscribers even if the Blue Cross itself could not reimburse the hospital for the costs of the care. The subscriber thus had a direct contractual relationship with the hospital, a community institution; there was theoretically no need for subscribers to worry about the solvency of the Blue Cross plan or its ability to manage large cash reserves.

The final unique aspect of Blue Cross, so taken for granted at the time that it is rarely mentioned in the contemporary literature, is the prohibition on competition between Blue Cross plans. The Commission on Hospital Service standard expressly provides that "Plans should be established only where needs of a community are not adequately served by existing non-profit hospital service plans." As we have already noted, this provision stemmed from a concern that the subscriber be afforded free choice of doctors and hospitals at the time of illness. However, the ideal of one cooperative, inclusive organization is consistent with the hospital tradition of voluntary sector self-government. *See* Rorem, *supra* note 19, at 543-44.

Although these special characteristics were touted as establishing the public-service nature of the Blue Cross plans, it is clear that Blue Cross derived its special service aura principally from its sponsors, the nonprofit voluntary hospitals, rather than from any particular financial or underwriting practices.

hospitals took advantage of the stable and generous financing provided by widespread health insurance to improve the quality and sophistication (and expense) of their services in accordance with evolving standards of medical practice. By the late 1950s, rising hospital costs evoked both public concern and, in the states with large Blue Cross plans, political controversy over large and frequent Blue Cross rate increases.

By the late 1950s the hospitals and the Blue Cross were forced to recognize their interdependence and to pull closely together. Rising hospital costs were making voluntary health insurance unaffordable for retired persons; seeing themselves pushed out of the private health insurance system, the elderly coalesced as a political force around their need for government assistance. High costs had also made it increasingly difficult for voluntary hospitals to provide free care of the aged and the poor; the political debate over what form this assistance should take revived the issue of government health insurance.

The voluntary hospital establishment never opposed federal financing of health care costs as vigorously as did the American Medical Association, which represented physicians in private practice. The hospitals were accustomed to receiving state and local government reimbursement for the cost of caring for the poor, and the ties between the voluntary hospital and public health establishments had given the leaders of the voluntary hospitals experience in dealing with government organizations and broad public concerns. The voluntary hospitals did not try to prevent the federal government from coming to the assistance of the poor and the aged but sought rather to channel government action so that it would complement rather than supplant the system of private health insurance and would not result in governmental domination of the voluntary hospitals.

The voluntary hospitals' chief bulwark against universal government health insurance and therefore government domination was the system of private health insurance that was anchored by the Blue Cross. The Blue Cross was central not only to the hospitals' financial stability but to their institutional autonomy as well. As the Blue Cross came under financial pressure and political attack in the late 1950s the hospital establishment reasserted its leadership and drew the Blue Cross more closely into its orbit. By the end of the decade the Blue Cross had resolved the ambivalence in its relationship with the hospitals: it had become their instrumentality.

One of the circumstances driving the Blue Cross closer to the

hospitals was the rise of commercial health insurance. As health insurance became a popular fringe employment benefit in the postwar period, the Blue Cross began to experience strong competition from commercial insurance companies (principally life insurance companies) that could offer health insurance as part of comprehensive insurance packages that included life and disability insurance as well. The commercial insurance companies frequently used health insurance as a loss leader to attract customers for these other more profitable forms of insurance, undercutting Blue Cross rates for health insurance in the process. More importantly, the large commercial insurance companies could offer uniform company-wide benefits under a single national contract to large employers with nationwide operations.<sup>31</sup> The Blue Cross, by contrast, was not designed for a national economy. It consisted of a loose federation of largely autonomous, fundamentally localist plans with different benefit structures and accounting practices. The challenge of the 1950s was to coordinate the plans sufficiently that a unified Blue Cross organization could compete with the commercial insurance companies for national contracts.<sup>32</sup>

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31. See Schonbrum, *The Future of Blue Cross*, 2 J. HEALTH POL., POLY & L. 319, 327-39 (1977). Health insurance became one of the most popular employee fringe benefits in the postwar period, largely because the federal tax laws did not require employees to include in their own gross income the amount of their employer's contribution to the cost of their health insurance plans. See Steurle & Hoffman, *Tax Expenditures for Health Care*, 30 NATL. TAX J. 101, 101-02 (1979). Another major impetus was the inclusion of employee welfare plans (including health insurance plans) as a mandatory subject of collective bargaining under the Taft-Hartley Act. See *Inland Steel Co.*, 77 NLRB 1, *affid.*, 170 F.2d 247 (7th Cir. 1948), *affid. on other grounds sub nom.* *American Communications Assn. v. Douds*, 339 U.S. 382 (1950); R. MUNTS, *BARGAINING FOR HEALTH: LABOR UNIONS, HEALTH INSURANCE, AND MEDICAL CARE* 9-12 (1967).

32. Blue Cross made a vigorous effort to "go national." In 1946 the Commission on Hospital Service founded by Dr. Rorem had been redesigned to form the Blue Cross Commission, which served as the national coordinating agency among the various state and provincial plans (Canadian plans were affiliated at the time but later withdrew). The BCC operated as a commission of the American Hospital Association. In 1949 the Blue Cross Commission formed the Blue Cross Association, a nonprofit corporation, for the purpose of establishing a stock national insurance company, Health Services, Inc., to provide uniform group benefits on a national basis. It replaced the local Benefit Agreement for National Accounts, which had left administrative control over joint arrangements in the hands of local plans.

Health Service, Inc. did not, however, capture the national market. Competition with commercial carriers had become very intense. By 1955 growing dismay prompted leaders of the most successful Blue Cross plans to meet discreetly to develop a strategy for national enrollment. These efforts were channeled through the Blue Cross Association, the Blue Cross plans' own organization, rather than the Blue Cross Commission affiliated with the AHA.

In 1960 the AHA and the Blue Cross Commission membership voted to merge the functions of the Blue Cross Commission and the BCA. The AHA dissolved its Blue Cross Commission and formed the AHA Council on Blue Cross Prepayment and Financing, one half of whose members were Blue Cross personnel, to supervise the approval of new Blue Cross plans, licensing of the Blue Cross symbol, and hospital reimbursement methods. The BCA itself assumed those functions of the old Blue Cross Commission concerned primarily with the national interrelationships of the plans. The BCA and the AHA established an interlocking



The Blue Cross and the voluntary hospital establishment did not welcome the rise of commercial health insurance: competition threatened the internal subsidies within the Blue Cross rate structure and therefore its viability as a substitute for government health insurance. The Blue Cross's rate structure was based on the principle of "community rating," under which subscriber rates represented a pooling of risk among low-risk and high-risk groups. Commercial insurers could undersell the Blue Cross by offering lower premiums to groups with more favorable hospital utilization experience, a practice known as "experience rating." If the Blue Cross met the commercial competition by lowering its rates to the low-risk groups, it was forced to increase rates for higher-risk groups, who tended also to have limited financial resources because they were retired, or lived in rural areas, or worked in low-paying employment.

Competition thus impaired the ability of the Blue Cross to hold itself out as a substitute for government health insurance that could offer affordable protection to high-risk groups. At the same time, commercial companies were not an altogether reliable source of health insurance even for low-risk groups. Not being committed to making health insurance available to the public, commercial insurance companies might offer health insurance one year but not the next. Although they competed with the Blue Cross in its most attractive markets, they did not serve the same function vis-à-vis the voluntary hospitals that the Blue Cross served, which was to provide a stable and affordable alternative to government health insurance for the broad middle ranges of the population.

Finally, the commercial insurers were not committed to the hospitals as institutions. They were in the business of writing insurance, not providing health care; they were not committed to generating a stable income for the hospitals and did not structure their policies, as the Blue Cross tended to do, to encourage hospital utilization. The commercial companies wrote indemnity contracts that included deductibles or co-insurance, creating financial disincentives to the use of hospital services; in a competitive environment they would naturally be cost-conscious, and the hospitals feared that if the commer-

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board membership: three AHA representatives served on the BCA board, two BCA representatives on the AHA board. BCA moved into the AHA headquarters building in Chicago.

The interlocking directorate between the AHA and the BCA lasted from 1960 until 1971, when the organizations decided to disentangle themselves. In 1972 the AHA transferred ownership of the Blue Cross name and emblems to the BCA. The severing of the organizations at the national level did not affect the compositions of the boards of directors of the state Blue Cross plans, most of which under state enabling statutes were required to have hospital representatives. See O. ANDERSON, *supra* note 15, at 69-73; R. EILER, *supra* note 10, at 55-69; S. LAW, *BLUE CROSS: WHAT WENT WRONG?* 19 (2d ed. 1976).

cial companies ever achieved dominance in the health insurance market they might use their market position to institute controls over the hospitals, including cost controls, that would constrain the growth of the hospital sector.<sup>33</sup>

The hospitals' symbiotic relationship with the Blue Cross allowed them to keep the commercial carriers at a distance. The hospitals and the Blue Cross also actively attempted to disadvantage the commercial companies relative to the Blue Cross. The reimbursement formula negotiated between the Blue Cross and the hospitals typically resulted in a price advantage known as the "Blue Cross discount." Hospitals also allowed Blue Cross subscribers, unlike commercially insured patients, to be admitted to the hospitals without a deposit.<sup>34</sup>

Notwithstanding competition from commercial insurance com-

33. The Blue Shield, which is the physicians' service plan for medical and surgical benefits, was formed largely in order to protect physicians against oversight by independent health insurance plans. See generally Goldenberg & Greenberg, *The Effect of Physician-Controlled Health Insurance: United States v. Oregon State Medical Society*, 2 J. HEALTH POL., POLY. & L. 48 (1977).

34. Hospitals bill "charges" to patients who are responsible for their own hospital bills, including those covered by commercial insurance. By contrast, if a patient is a Blue Cross subscriber, the hospital recovers from the Blue Cross its cost of treatment under a reimbursement formula specified in its contract with the Blue Cross. The customary method is simply to divide the hospital's total allowable costs by the number of its total patient days, producing a *per diem* rate that the Blue Cross pays for each day of subscriber hospitalization. The *per diem* rate thus derived is usually lower than the *per diem* "charges" billed to patients covered by commercial insurance. The difference is commonly known as the "Blue Cross discount"; the commercial insurance companies believe that it gives the Blue Cross an unfair competitive advantage. See *Travelers Ins. Co. v. Blue Cross*, 361 F. Supp. 774 (W.D. Pa. 1972), *aff'd.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973) (upholding the Blue Cross discount against antitrust challenge).

In the late 1940s the commercial insurance companies attempted to eliminate the hospitals' practice of demanding deposits before admitting patients who were covered by commercial insurance. The commercials developed a means whereby the hospitals could quickly ascertain a patient's insurance status, and asked hospitals to discontinue the deposit requirement for patients whose status had been verified.

The Michigan Hospital Association opposed the request after the executive director of the Michigan Blue Cross, with the support of several other members of the hospital association who were also Blue Cross directors, made an impassioned speech pointing out the importance to the hospitals of maintaining the competitive viability of the Blue Cross. Excerpts follow:

Hospitals in many metropolitan areas are being subjected to a systematic and high-powered pressure campaign by the commercial insurance companies. . . .

. . . The real objective of the insurance companies is to force the hospitals into an agreement that would give them a serious competitive advantage over Blue Cross. . . .

. . . Let us suppose that after forcing the hospitals into arrangements that weakened Blue Cross, the insurance companies — six or a dozen of them — managed to develop the volume of business that Blue Cross has now, with Blue Cross forced into a secondary position. . . .

. . . If private insurance should take away from Blue Cross such groups as General Motors, Ford, United States Steel and American Telephone and Telegraph, as they have already taken away Sears, Roebuck and Company, Burroughs Adding Machine, Standard

panies, the Blue Cross remained the dominant force in the health insurance market. Blue Cross was particularly strong in the eastern, midwestern, and New England states, which were also the states in which suburban growth posed a threat to existing large hospitals in older downtown areas.

Not surprisingly, these were also the states in which the voluntary hospital establishment had long traditions of self-governance, able leadership, and close relationships with the public health establishment. The problems and opportunities of the late 1950s in these states shaped the terms of the hospital-Blue Cross-public health alignment that gave rise to regulation of hospital construction through regional planning.

### III. FAULTS IN THE STRUCTURE: THE MICHIGAN BLUE CROSS IN WARTIME AND POST WAR PROSPERITY

It was not until health insurance became widely available in the mid-1950s that rising hospital costs began to be perceived nationally as an inherent problem of the hospital industry. Michigan, however, whose Blue Cross plan grew rapidly during World War II, furnishes an early example of the dramatic hospital cost inflation that would erupt as a national pattern in the postwar period. We can also see in Michigan the increasing financial interdependence of the voluntary hospitals and the Blue Cross as the hospitals came to rely on the Blue Cross for the major part of their income.

The Michigan Blue Cross came into being in a familiar way. The Michigan Hospital Association had observed the progress of prepaid hospital service plans in various parts of the country, and early in 1938 it resolved to promote a statewide plan for Michigan.<sup>35</sup> The idea caught on quickly with local hospital associations, and the Michigan Hospital Service enrolled its first subscriber in March 1939.

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Oil, Hudson Motor Company, and many others, then the beginning of the end of Blue Cross would be in sight.

. . . . Should Blue Cross be crippled, it will be but a short time before the government will take over. . . .

In that eventuality there will be no hospital insurance business for either the private companies or Blue Cross. Then, of course, there will not be any private hospitals either.

The hospitals face an issue of grave importance. The hospitals must make the decision.

McNary, *Hospitals Must Make the Decision*, HOSPITALS, Apr. 1951, at 76-80. In addition, see L. DRAKE & S. HANNA, HISTORY OF MICHIGAN HOSPITAL SERVICE, 1938-1951, at 56-57 (undated; evidence suggests preparation during 1952).

35. Unless otherwise noted, historical material in this part is drawn from L. DRAKE & S. HANNA, *supra* note 34.

Within a year of its founding, the Michigan plan had enrolled 175,000 subscribers. By 1941 it had contracts with the major automobile manufacturers and a total of 225,000 subscribers: it had become the second largest Blue Cross plan in the country. Its troubles began immediately.<sup>36</sup>

The problem was rising hospital costs. A year after bringing in the automobile company employees, Michigan Blue Cross had to raise its rates because hospital costs had increased by twenty-four percent from 1940 to 1942. A modest rate increase was accompanied by a liberalization of benefits. Enrollment continued to grow, and costs continued to rise. Rates were raised by fifteen percent in 1945, and benefits were again liberalized. When the increased revenue proved insufficient, rates were again raised in 1946. At the time, the cost increases were attributed to a war-time shortage of medical personnel, the unattractiveness of hospital employment because of better opportunities in defense production, and a pent-up demand for medical services on the part of industrial workers and their families, many of whom had never before had access to professional medical services. Rising costs were thought to be a temporary problem that would disappear with the return of normal peacetime employment conditions.

In the meantime, however, the hospitals were becoming restive. Their service benefit contracts called for them to render specified services even if Blue Cross reimbursement did not cover their full costs. In January 1946 the Sisters of Mercy withdrew their fourteen hospitals from participation in Blue Cross, claiming that they were incurring losses on patients admitted under the plan. The withdrawal of so many prominent institutions, coupled with widespread reports of the impending insolvency of Blue Cross, precipitated a crisis. The plan director, whose strength was in promoting enrollment and who had no background in hospital administration, resigned. The staff and board were reorganized. The Insurance Commissioner prohibited the plan from selling new contracts.

The crisis of 1946 resulted in a critical realignment of Michigan Blue Cross objectives and operations toward a closer relationship with the hospitals and more sympathetic reimbursement practices. In order to attract back the Sisters of Mercy and to prevent the withdrawal of other hospitals, the Board abandoned its practice of reim-

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36. The wartime growth of hospital insurance was stimulated by the National War Labor Board's policy of allowing increases in nonwage benefits while wage increases were constrained by federal wage and price controls. See O. ANDERSON, *supra* note 15, at 45.

bursing on a flat fee basis<sup>37</sup> and moved to an actual-cost basis, with a preliminary payment of ninety percent of charges, subject to adjustment after the determination of individual institutional costs.<sup>38</sup> This more flexible policy satisfied the hospitals. Once the Blue Cross had accepted the premises of individualized full-cost retrospective reimbursement, however, its power to hold down its rates depended on its ability to force the hospitals to control their own costs. The close relationship between the Blue Cross and the hospitals made it impossible for the Blue Cross to exercise any such authority. Blue Cross rates would henceforth be tied directly to hospital costs.

The increasing financial interdependence of the Michigan Blue Cross and the hospitals made it imperative that they establish a closer operating relationship. The first major action of the new Blue Cross executive director<sup>39</sup> was to establish closer organizational ties between the Blue Cross and the participating hospitals by creating a new twelve-member Hospital Relations Committee, consisting of

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37. The original reimbursement practice of the Blue Cross plans was to pay the same per diem rates to all hospitals. This was consistent with the standard government practice in paying for charity patients. As the hospitals came to rely increasingly on Blue Cross reimbursement, however, they demanded recognition of their individual cost characteristics — size, teaching responsibilities, caseload mix, and similar factors — in the computation of costs. The hospitals did not engage in cost accounting except insofar as they needed to justify cost-based reimbursement rates to major third-party payors. The American Hospital Association's cost accounting manual, for example, was provided in response to the federal government's Emergency Maternity and Infant Care program under which the government paid the cost of hospital care for the wives and dependents of military servicemen during World War II. *See id.* at 43-44. The current generation of AHA standards were developed in order to influence the definition of "reasonable cost" under Medicare. *See* H. SOMERS & A. SOMERS, *MEDICARE AND THE HOSPITALS* 154-58 (1967).

38. *See* L. DRAKE & S. HANNA, *supra* note 34, at 39.

39. The person hired by the Michigan Blue Cross in 1947 to be its executive director and general manager was William S. McNary, who had helped to found the Colorado Blue Cross plan and served as its director for ten years. Prior to that time he had been the business manager of the University of Colorado School of Medicine and Hospitals. The careers of Blue Cross leaders show a pattern of movement within the university hospitals, the public health establishment, and the Blue Cross. *See* notes 46, 84, 94 *infra*. The first executive director of the Michigan Hospital Service (not McNary's immediate predecessor) was an authentic Blue Cross pioneer, John R. Mannix, who had come from the University Hospital in Cleveland, Ohio, the site of an early and successful hospital service plan. After leaving Michigan he returned to Cleveland to become director of the Blue Cross.

George Bugbee, who served for many years as executive director of the American Hospital Association, had been an assistant director of the University Hospital in Ann Arbor, and then a member of the faculty at the University of Chicago Graduate School of Business. He served as Commissioner of Metropolitan General Hospital in Cleveland during the late 1930s and early 1940s, when Harold H. Burton, who later sponsored the Hill-Burton Act, was mayor of Cleveland. After leaving the AHA in 1954 Bugbee became the president of the Health Information Foundation in New York; he is listed as having represented the New York City Blue Cross at the first legislative meetings held to design what became New York's certificate-of-need laws. *See* NEW YORK JOINT LEGISLATIVE COMMITTEE, *REPORT ON HEALTH INSURANCE PLANS* 45, Legislative Doc. No. 44 (1961) [hereinafter cited as 1961 JT. COMM. REPORT]. From 1962 to 1970 Bugbee served as the director of the Center for Health Administration Studies and the graduate program in hospital administration at the University of Chicago.

four trustees of the Michigan Hospital Service and eight members representing participating hospitals. The Hospital Relations Committee customarily met immediately before MHS Board meetings and screened Board agenda items involving hospital matters. The participating hospitals also formally controlled (1) twenty-one of the forty-one seats on the MHS board of Directors; (2) an unascertainable number of the "public representatives," many of whom were nominated by the hospitals; and (3) the hospital district councils, which had direct relationships with the Blue Cross staff.<sup>40</sup> This organizational structure and staff ensured henceforth that Blue Cross policies would reflect more closely the institutional interests of the participating hospitals. "Hospital thought was now part and parcel of Blue Cross thought. The prepayment program had to meet the need of the people but also the need of the hospitals."<sup>41</sup>

What direction would the new team take? In his first annual report, the new President reported that:

Hospital costs have risen more rapidly during the year 1947 than during any other period, at least since World War I. . . . [H]ospital payments by Michigan Hospital Service have increased materially. These increases have come to a point where we can no longer operate except at a deficit, and some new method of handling the situation must be devised either by increasing premiums or changing hospital payments or benefits.<sup>42</sup>

Certainly this assessment was accurate. The Blue Cross could theoretically have avoided further deficits by reducing the patients' entitlements to services or by allowing less generous reimbursement to the hospitals. In fact, however, the Michigan Hospital Service could do nothing but raise rates to subscribers: it did not control the level of benefits offered in its major contracts, which were arrived at in collective bargaining in the automobile industry, and it was powerless to change the reimbursement formula that it had just negotiated with the participating hospitals, a formula that would inevitably loosen whatever internal cost constraints had been encouraged within the participating hospitals by the flat fee reimbursement policy. Over the next two years premiums were raised twice — in 1948 and 1949 — and benefits were liberalized, making the Michigan Blue Cross the most comprehensive and expensive plan in the country.

The dynamics first evidenced in Michigan during the war were

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40. See L. DRAKE & S. HANNA, *supra* note 34, at 42-47.

41. *Id.* at 48.

42. *Id.* The new president of the Michigan Blue Cross was E. Dwight Barnett, the director of Harper Hospital, one of Detroit's largest and most prestigious hospitals. Shortly thereafter, Dr. Barnett became the head of the Columbia University Institute of Administrative Medicine.

repeated in other Blue Cross plans around the country. The Blue Cross grew dramatically in the postwar period. Full-cost reimbursement became standard; hospital costs rose rapidly, and the increasing dependence of the hospitals on the Blue Cross made it necessary for the hospitals to pull the Blue Cross more tightly into their orbit.

#### IV. THE POSTWAR PERIOD: EXPANSION, ANXIETY, AND THREAT

The health care system grew dramatically in the 1950s along with, and in part because of, the spread of health insurance. Insurance had liberated voluntary hospital administrators from the need to rely on charitable fundraising drives for their operating income. The dominant trend in the 1950s was one of growth, both of individual hospitals and of the system as a whole, as metropolitan areas mushroomed. But growth threatened to produce a great heterogeneity of institutions: an established 500-bed voluntary hospital in a central city might well find another 100-bed institution being planned for half a mile away, a 25-bed hospital being built around the corner, construction in progress on two 200-bed facilities within a five mile radius, and talk of three more 250-bed hospitals in the inner suburban ring. All of these hospitals would typically meet state licensing requirements, which dealt principally with minimum construction standards. All of them would be economically viable because health insurance had stimulated an apparently insatiable demand for hospital services.

Unplanned growth threatened the large downtown voluntary hospitals, which after the mid-1950s were facing the drain of middle-class patients and financial resources out of the center cities. This migration did not mean that the large hospitals would go out of existence; it did mean that they could lose their pre-eminence. The large voluntary hospitals usually had teaching programs and often were affiliated with medical schools. They were the centers of elite medical practice. Nearly all of them had been built before the Depression. Newer hospitals with more attractive and modern facilities, located close to the places where the middle-classes were moving their homes, might well attract specialist-physicians to their staffs and disperse the pool of patients most suitable as teaching material, resulting in a decline of the teaching function of the large downtown voluntary hospitals. Teaching hospitals needed teaching patients. And it was the teaching function — and the resulting presence of residents and interns on the hospital “house staffs” — that made possible the specialized and sophisticated care on which the reputations of the large institutions were founded.

The demographic and market forces that threatened the large voluntary hospitals imperiled an entire system of interrelationships among those hospitals, the medical schools, the research-funding government agencies, and the private foundations. These institutions had centered their activities on the large voluntary teaching hospital. Their preferences had been adopted as basic federal policy in the Hospital Survey and Construction Act of 1946, known popularly as the Hill-Burton Act.<sup>43</sup> The United States Public Health Service and the state agencies charged with hospital planning under the Hill-Burton Act now joined forces with the voluntary hospital establishment to support the large voluntary hospitals. They proposed to control growth through regional hospital planning. They were supported by the voluntary hospitals' planning councils.

The idea of hospital planning predated the 1946 Hill-Burton Act. Hospital planning had first been seriously undertaken during the boom years of the 1920s — a time when it seemed important to provide the public with sufficient hospital facilities.<sup>44</sup> Efforts to quantify a proper proportion of hospital beds to population, sponsored by private foundations and the American Hospital Association, continued throughout the decade. These studies were concerned primarily with the gross ratio of beds to population; they did not focus on relationships among the hospitals themselves. The idea of a regionally coordinated health care system was discussed nationally in the mid-1940s, when the hospital establishment began to plan for the postwar era.<sup>45</sup> The large modern hospital was to be the center of the system; working relationships between larger and smaller hospitals were to be developed to foster the dissemination of advanced medical techniques. In addition, hospitals within a region were to interchange services and equipment and arrange for the integration of services

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43. PUB. L. NO. 79-725, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-2910 (1976)). Although the Hill-Burton Act was designed to aid construction of rural hospitals and in fact resulted in the construction of many smaller hospitals in underserved areas, the theory was that these hospitals would be satellites to larger voluntary hospitals in urban or "base" areas.

44. The first serious study was undertaken by the New York Academy of Medicine in 1920. See J. MAY, HEALTH PLANNING: ITS PAST AND POTENTIAL 13-40 (1967), for a review of health planning prior to the Hill-Burton Act.

45. See *id.* at 19-22. See generally COMMISSION ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES (1947). The Commission was established under the sponsorship of the AHA Committee on Postwar Planning, and was financed with grants from the Commonwealth Fund, the W. K. Kellogg Foundation, and the National Foundation for Infantile Paralysis. Its recommendations are closely identified with the Commonwealth Fund, which published the final study. The study director of the Commission was Arthur C. Backmeyer, who was director of the University Clinics and associate dean of the division of biological sciences at the University of Chicago. He had previously served as president of the American Hospital Association.



among institutions.<sup>46</sup>

The original Hill-Burton Act endorsed both the idea of a quantified standard for determining the proper ratio of hospital beds to population and the idea of a tiered regional hospital system centered on large institutions in urban areas, coordinated through community-based, voluntary planning agencies operating under state guidance. The Act was designed to bring the best scientific medicine as practiced and taught in the finest hospitals within the geographical reach of all Americans.<sup>47</sup>

In drafting men for service in World War II, the army had discovered that a large percentage of the draftees were unfit for service, particularly draftees from medically underserved rural areas. The nationwide program of hospital construction, authorized by the Hill-Burton Act, was intended to distribute high-quality hospitals more evenly throughout the country in order to allow returning servicemen to continue to enjoy the standard of care to which they had become accustomed in the military. It was also intended to provide practice opportunities for military doctors who had become accus-

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46. The Commission on Hospital Care advocated a system of formal relationships among the hospitals, and suggested that government might force the hospitals to coordinate their activities if they failed to do so voluntarily. This idea was highly distasteful to the hospitals and found few adherents. See J. MAY, *supra* note 44, at 19-24. The voluntary hospitals believe they should be left alone to plan and coordinate among themselves, with some participation by major consumer groups such as business and labor and by community leaders committed to the values of the voluntary system. The public health establishment has supported voluntary self-government, but believes in selective government intervention where private action fails to protect important public interests. The leadership of the university-based element of the public health establishment, which is frequently called upon to help resolve disputes over whether government intervention to solve a particular problem is necessary or desirable, has frequently advocated government intervention to support elite voluntary decisionmaking.

The person who was credited with having first suggested government licensing of hospital construction as a response to the political pressure for cost containment in the late 1950s was Ray E. Brown. See note 81 *infra*. The person who persuaded the New York hospital establishment that construction licensing was in its collective best interest was Dr. Ray Trussell, Dean of the Columbia University School of Public Health and Administrative Medicine. See text at note 83 *infra*. Dr. Trussell has told the authors that he used the advisory committees to the *Trussell Report* study team as a forum in which to work out doubts about the necessity and wisdom of seeking government action.

47. This Article will use the following terminology in describing hospital size unless the context indicates otherwise:

"smallest": fewer than 50 beds

"small": fewer than 100 beds

"intermediate": 100-200 beds

"large" or "larger": 200 or more beds

"largest": 500 or more beds

Many hospitals operate internship and residency postgraduate training programs for physicians. All hospitals with such programs will be described as "teaching hospitals." Some such institutions have formal relationships with medical schools and will be described as "medical school affiliates." Hospitals that are owned by universities will be described as "university hospitals." These designations are unrelated to size unless indicated by the context.

tomed to high-quality facilities,<sup>48</sup> on the theory that good doctors would locate in communities with good hospitals. The program also responded to Congress' need to stimulate the postwar economy.

The Hill-Burton Act marked the first major federal government involvement in general health matters. It made possible a great expansion of hospital capacity throughout the nation, chiefly in non-profit hospitals; it also enshrined in federal law, policy, and institutions the thinking and preferred institutional arrangements of the voluntary hospital establishment.<sup>49</sup> It was in fact the product of a close collaboration between the United States Public Health Service and the American Hospital Association.<sup>50</sup>

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48. Students of the welfare state have noted that expenditures for national equality-promoting social programs typically rise as a result of universal military service. See M. JANOWITZ, *THE LAST HALF-CENTURY* 165-66 (1978); H. WILENSKY, *THE WELFARE STATE AND EQUALITY* 70-74 (1975). The Hill-Burton Act can usefully be viewed as a politically achievable alternative to national health insurance, which was opposed bitterly by the private health care sector. The American Hospital Association prevented the American Medical Association from opposing the Hill-Burton Act. Although the AMA in principle approved of providing more hospital facilities to support the private practice of medicine, it suspected (prophetically) that hospital construction would lead to an increasing emphasis on specialists to the detriment of general practitioners, who were the backbone of the AMA's constituency.

The Act also contained one of the first federal nondiscrimination provisions, forbidding a hospital receiving Hill-Burton funds to discriminate on the basis of race, creed or color; it incorporated, however, the prevailing "separate-but-equal" standard allowing state plans to provide separate facilities on the basis of need for separate population groups, as long as facilities and services were of like quality. See *Hospital Survey and Construction (Hill-Burton) Act*, Pub. L. No. 79-725, § 622(f), 60 Stat. 1043 (1946); *Hearings Before the Comm. on Education and Labor on S. 1661*, 79th Cong., 1st Sess. 318-20 (1945) (testimony of Dr. Dorothy Boulding Ferebee on behalf of the National Nonpartisan Council on Public Affairs of Alpha Kappa Alpha Sorority).

49. The continuing influence of the voluntary sector in implementing the Hill-Burton Act was assured by requirements that public officials at all levels consult with the leaders of the hospital industry and other voluntary groups with an interest in health policy prior to formulating public policies. Participating states were required to appoint state advisory councils to represent nongovernment organizations, consumer interests, and state agencies concerned with the operation, construction, or utilization of hospitals. See *Hospital Survey and Construction (Hill-Burton) Act*, Pub. L. No. 79-725, § 612(a)(2), 60 Stat. 1041 (1946). The Surgeon General of the United States, who was charged with developing administrative rules and regulations, was directed to consult with a Federal Hospital Council consisting of eight members in addition to himself. Four members were to be persons "outstanding in fields pertaining to hospital and health activities, three of whom shall be authorities in matters relating to the operation of hospitals," and the other four were to be appointed to represent the consumers but did not apparently have to be consumers themselves. These last four were to be "persons familiar with the need for hospital services in urban or rural areas." See *Hospital Survey and Construction (Hill-Burton) Act*, Pub. L. No. 79-725, § 633, 60 Stat. 1048 (1946).

The Hill-Burton Act affirmed the primacy of voluntary sector and state governments in the construction and operation of hospitals. It also enshrined in federal policy the idea first developed by the voluntary hospitals that the distribution of hospitals should be based on need, determined objectively and expressed as the ratio of hospital beds to population. Planners became accustomed to thinking of the number of hospital beds as a measure of hospital system capacity. When hospital costs became a major problem in the late 1950s, the planners equated controlling the number of hospital beds with controlling hospital costs. See Appendix I, *infra*.

50. In an interview granted much later, George A. Bugbee, who served as executive director of the American Hospital Association from 1943 to 1954, referred to passage of the Hill-

Hill-Burton planning was intended to encourage the most sophisticated hospitals to dominate the health care system: within the overall constraint of 4.5 beds per thousand population, state agencies were to decide which areas should constitute *base* areas (containing a medical school or hospital of more than 200 beds), *intermediate* areas (containing more than 25,000 population and at least one hospital with more than 100 beds) and *rural* areas (the residual category). Hospitals in the base areas would be centers for teaching, research and sophisticated referral care; they would disseminate the best medical practice throughout their regions and would attract doctors seeking opportunities for specialty practice.<sup>51</sup>

Although the idea of regional planning underlay the Hill-Burton Act, the only authority over construction decisions of the voluntary hospitals that the planning agencies derived from the Act was their ability to grant or deny Hill-Burton funds. In states with high per capita incomes and therefore low Hill-Burton allotments, the contribution made by the Hill-Burton program to hospital capital formation was quite modest.<sup>52</sup> The actual influence of the Hill-Burton Act on the pattern of hospital construction in major metropolitan areas in the 1950s was therefore slight.

The Hill-Burton Act required that planning be carried out by regions; however, the regional planning agencies entrusted with this task, most of which were the creations of state government, did not

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Burton Act as the single most important achievement of the AHA in the 1940s. See Crosby, *An Interview with George Bugbee*, HOSPITALS, Jan. 1, 1959, at 34-35. A pilot survey of bed needs done by the Commission on Hospital Care had been the basis for the Act and for many of the regulations and administrative practices incorporated into it. See 2 W. MCNERNEY, HOSPITAL AND MEDICAL ECONOMICS 1371 (1962).

51. The Hill-Burton scheme committed health planners to protect the quality of the base hospitals, which had to be large enough to support the facilities necessary for sophisticated care. Any health care system therefore had to be designed to provide the base hospitals with sufficient patients to fill their beds and maintain their teaching programs. See Klarman, *Planning for Facilities* in U.S. DEPT. OF H.E.W., REGIONALIZATION AND HEALTH POLICY 25 (1977). Regionalization also contemplated a division of the market for patients: the base hospitals were to be referral hospitals for the most difficult cases. Theoretically, community hospitals (100-200 beds) serving intermediate areas would handle only routine problems; rural hospitals could be small (30-50 beds) even though small hospitals were generally disfavored.

All proponents of the legislation had an interest in preventing the Hill-Burton program from becoming a federal pork barrel program. The program was designed as a system of grants-in-aid to state governments, with a distribution formula that provided a higher federal share to states with lower per capita incomes. See Hospital Survey and Construction (Hill-Burton) Act, Pub. L. No. 79-725, § 631, 60 Stat. 1046 (1946). In order to forestall the possibility of political domination of construction decisions, the Act required that the state survey its hospital needs under federal planning guidelines, see Hospital Survey and Construction (Hill-Burton) Act, Pub. L. No. 79-725, § 623, 60 Stat. 1043-44 (1946). The U.S. Public Health Service had given its imprimatur to the idea that 4.5 short-term general beds per thousand population was appropriate; this number became the federal standard under the Hill-Burton Act. See J. MAY, *supra* note 44, at 16.

52. See J. LAVE & L. LAVE, THE HOSPITAL CONSTRUCTION ACT 17-18 (1974).

have authority to force cooperation between and among voluntary hospitals as the fully articulated regional planning concept required. In most of the country, the regional planning concept lay dormant. In a few states, however, including Michigan and New York, the hospitals' own voluntary regional planning councils had predated the Act.<sup>53</sup> They represented the voluntary hospitals' commitment to both collective self-governance and the regional planning idea that had been incorporated into the Act itself. The activities of these councils during the late 1940s and early 1950s made concrete the idea of regional planning as collective and cooperative action among the voluntary hospitals. When the regional planning concept in the Hill-Burton Act was revived in the late 1950s, these councils were looked to as models.

The revitalization of regional planning was a joint undertaking of the American Health Association and the United States Public Health Service. In 1959 these two organizations sponsored four major regional conferences titled "Principles for Planning the Future Hospital System."<sup>54</sup> These efforts matured into federal comprehensive health planning legislation in the 1960s. The sponsorship of these conferences by the United States Public Health Service reaffirmed the federal government's support of the principles of regional planning as practiced by the major voluntary hospital councils.

By the late 1950s, however, the concept of regional planning had been modified in light of the new problems created by suburban

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53. In Michigan the Greater Detroit Area Hospital Council was one of the early community-based voluntary planning agencies. In addition to its coordination functions it was already involved in reviewing proposals for construction by voluntary hospitals and in channeling suburban hospital growth. See 2 W. MCNERNEY, *supra* note 50, at 1255.

In New York, similar councils had existed in New York City and Rochester before the advent of the Hill-Burton program as voluntary community-wide planning agencies. The Hospital Council of Greater New York, in addition to holding Hill-Burton authority, commonly reviewed proposals for construction or expansion submitted by the voluntary hospitals built with private funds in the New York metropolitan area. So far as we have been able to determine, no other council in New York State had such a role with respect to voluntary hospitals.

Agencies such as these must be seen as part of the hospitals' general allegiance to the practices of elite voluntarism, which have historically included united fundraising campaigns and collective planning for voluntary social service agencies on a community-wide or regional level. See W. TRATTNER, *FROM POOR LAW TO WELFARE STATE* 80 (2d ed. 1979); PEOPLE AND EVENTS: A HISTORY OF THE UNITED WAY 20, 39 (1977); J. SEELEY, B. JUNKER & R. JONES, *COMMUNITY CHEST* 19-21 (1957). See generally F. WATSON, *THE CHARITY ORGANIZATION MOVEMENT IN THE UNITED STATES* 222 (1922).

54. See U.S. PUBLIC HEALTH SERVICE, *PRINCIPLES FOR PLANNING THE FUTURE HOSPITAL SYSTEM* (1959). In 1961, the United States Public Health Service and the American Hospital Association issued their influential report *AREAWIDE PLANNING FOR HOSPITALS AND RELATED FACILITIES*. See note 68 *infra*. The fact that Jack Masur, M.D., the Assistant Surgeon General of the United States, became President-elect of the American Hospital Association in 1960 is further evidence of the close relationship between the two organizations.

growth. The purpose of regional planning as originally expressed in the Hill-Burton Act was to bring hospitals to sparsely-populated, medically underserved areas that could not generate sufficient capital to provide adequate hospital facilities. The problem posed by the suburban building boom of the 1950s was almost exactly the opposite. Hospital construction was proceeding too rapidly, in response to high effective demand. The purpose of regional planning in the 1950s was to inhibit capital formation and to structure the growth of the hospital industry in suburban areas. It was the voluntary hospital and public health leadership, particularly in areas with older, more established planning councils, that adapted the concept of a tiered regional system, originally formulated as a division of responsibility between urban, small town, and rural hospitals, into a model applicable to hospitals *within* an urban area. All hospitals within a metropolitan area were to be large, if possible, but hospitals would be distinguished by their functions. The downtown hospitals would be tertiary care institutions; the others would be community hospitals that would continue to refer teaching material to the more sophisticated institutions. Michigan, with a long tradition of voluntary hospital collective self-governance, provided leadership in the revival of planning, which came to be called "areawide planning."

Early in the 1950s, the Detroit District Hospital Council attempted to channel suburban hospital construction into a tiered regional pattern. It generated private capital for hospital construction in the growing suburban areas through the Metropolitan Detroit Building Fund Appeal, which campaigned in 1951 and again in 1957. Funds were raised for an orderly expansion of the total metropolitan hospital system: four 250-bed hospitals were built in the suburban areas, and were designed to be satellites to the downtown private voluntary teaching hospitals.<sup>55</sup> The success of this planning effort depended, however, on the Council's ability not only to generate capital for the projects it favored, but also to prevent the creation of hospitals that were not part of its plan. This it could not do: hospitals were springing up all over the Detroit metropolitan area at just the time when the planned hospital construction was about to be completed with proceeds from the second building fund drive. The effective market demand for hospital services, buoyed by widespread health insurance, could have absorbed all of the new beds, authorized or not. The problem was that the cost of using the unauthorized

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55. The account of the building of the suburban hospitals is based on an oral history supplied to the authors by Symond Gottlieb, director of the Greater Detroit Area Hospital Council.

beds would be billed to the Michigan Blue Cross, which, like other major Blue Cross plans in the northeast and midwest, was in a state of financial panic.

The Blue Cross was required to reimburse the hospitals for the cost of rendering care to Blue Cross subscribers, but its own rates were controlled by state insurance commissioners. If subscriber rate increases lagged behind hospital cost increases, the Blue Cross would operate at a current deficit, would be forced to invade its reserves, and might even become bankrupt. On the other hand, frequent requests for rate increases exposed the hospitals and the Blue Cross to public controversy and political attack: largely because of the insurance commissioners' review function, rising hospital costs became a political issue in states with large Blue Cross plans.

By the late 1950s the forces leading to the hospital cost spiral had been identified. They included (1) inflationary increases in the cost of service even if the unit of service (*e.g.*, dressing a simple wound) was held constant; (2) the increasing technical sophistication of services available (*e.g.*, diagnostic radioisotopes); and (3) the increasing effective demand for hospital services resulting from progressively liberalized benefits in Blue Cross contracts. All of the foregoing trends, together with the mounting number of hospital beds in which patients could receive increasingly costly services, accounted for the steady rise in Blue Cross rates.

The public health and hospital establishments regarded most of these cost increases not as problems but as indicia of the success of the Blue Cross in bringing quality health care to the American people. The Michigan Blue Cross reported that every rate increase had been associated with an increase in benefits and pointed with satisfaction to "the remarkable job that is being done in Michigan . . . by the standard Comprehensive Blue Cross contract."<sup>56</sup> Although demand could theoretically have been reduced by instituting more limited coverage options, the Blue Cross reported that employees in Michigan, like federal workers, overwhelmingly chose high rather than low benefit coverage when offered the option.<sup>57</sup> The public health and hospital establishments similarly defended the cost increases that resulted from increases in quality, such as the more intensive use of equipment and employees per bed required by sophisticated treatment methods.<sup>58</sup>

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56. MICHIGAN HOSPITAL SERVICE, *THE STATUS AND OPERATION OF MICHIGAN HOSPITAL SERVICE 35* (1961) [hereinafter cited as 1961 MHS REPORT TO THE COMM.].

57. *See id.* at 36.

58. *See id.* at 75.

Other causes of increasing costs were also considered either unavoidable or actually desirable. Competition for workers after World War II had led to higher wages for all workers, including traditionally underpaid hospital employees. Hospital cost increases that reflected catch-up wage increases or reductions in the previously standard sixty-five hour workweek for hospital workers were easily justified.<sup>59</sup> Finally, some of the increase in *per diem* rates reflected more intensive utilization of beds: since patients tend to need more services during their first few days of hospitalization, more frequent patient turnover results in higher *per diem* costs that nonetheless may reflect a trend toward lower costs per patient.<sup>60</sup>

The reasons for individual hospital cost increases must be distinguished from the reasons for Blue Cross rate increases. The *per diem* charge to the Blue Cross under full-cost reimbursement principles represents fully allocated costs. The Blue Cross must therefore pay its share<sup>61</sup> of the fixed cost of the total hospital system (facilities and equipment) plus the costs that vary with patient utilization (*e.g.*, the number of bandages used). Blue Cross rates therefore depend on the total capital devoted to the hospital system and the variable costs generated by subscriber hospital utilization patterns (which in turn depend on how many subscribers are in the hospital during the course of a year, their average length of stay, and the nature of the illnesses for which they are hospitalized).

As its costs rose rapidly during the 1950s, the Michigan Blue Cross was caught in a dilemma. Most of the cost increases were due to factors discussed above that could be considered desirable. Some savings could be effected by shortening the average patient's length of stay, but the Blue Cross lacked the power and the desire to interfere in medical judgments.<sup>62</sup> It decided that the one thing it could control was the number of hospital beds. Areawide planning of hospital facilities provided the answer: the Blue Cross and the hospital planning council decided to use the Blue Cross dominance in the health insurance market to ensure that no more hospitals would be built without their approval, and to close the existing small hospi-

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59. *See id.* at 74.

60. *See id.* at 75.

61. The Blue Cross share will be determined by the number of a hospital's patients that are Blue Cross subscribers, where the hospital is a "participating hospital"; to nonparticipating hospitals, Blue Cross plans usually pay a flat fee not based on the institution's own costs.

62. At about this time the idea of physician peer review to reduce length of stay and unnecessary utilization began to be suggested seriously. *See* 1961 MHS REPORT TO THE COMM., *supra* note 56, at 43-44; SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE, PREPAYMENT FOR HOSPITAL CARE IN NEW YORK STATE: A REPORT ON THE EIGHT BLUE CROSS PLANS SERVING NEW YORK RESIDENTS 9 (1960) [hereinafter cited as TRUSSELL REPORT].

tals.<sup>63</sup> The Blue Cross determined that (1) only high-quality hospitals would be allowed to become "participating hospitals" and thus be eligible for full-cost reimbursement and (2) capital costs would be reimbursed only for new beds planned and built in accordance with community need.<sup>64</sup> Participation in the Blue Cross plan, in other words, was to be available only to large voluntary hospitals that consented to submit to a collective planning process.

If the planning council and the Blue Cross had been attempting to maximize cost savings by these actions, they would have missed their target. The smaller hospitals were the less expensive hospitals

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63. The hospital establishment's hostility to small hospitals can be understood as an effort to reduce the amount of competition in the hospital industry. Smaller hospitals can provide service to patients with uncomplicated diagnoses at lower average cost than larger hospitals whose average fully-allocated costs contain internal subsidies. The larger hospitals feared "cream skimming" — they feared that the smaller hospitals would attract the primary-care patients. Larger hospitals need primary-care patients not only to subsidize more expensive treatment of other patients, but also to provide subjects for their teaching programs and to protect their market for referral services. A dispersion of the pool of primary-care patients would force a reorganization of the teaching function to the detriment of the large hospitals. The presence of primary-care patients in large hospitals also conceals the actual costs of sophisticated types of treatment from the public and the third-party payor, thus reducing the potential for public controversy over the costs and benefits of such treatment.

In addition, the small hospitals posed several threats to the professional dominance of the existing large hospitals. First, the smallest hospitals (under 50 beds), which were either proprietaries or closely associated with a few doctors, were outside the standards of elite medical practice to which the large hospitals and their staffs were committed. Second, the small hospitals (50-100 beds) were a danger both because they could divert primary-care patients and because any one of them could grow into a larger institution. The market for medical services, sustained by health insurance, could apparently support any number of community hospitals; any existing respectable hospital could establish a genuine community base, seek charitable funds for capital expansion, and offer practice opportunities for doctors seeking staff privileges. The strategy of the hospital establishment was to force these smaller institutions to close or merge, thereby reducing the number of potential centers of hospital growth. Third, the intermediate-sized institutions (100-200 beds) could grow into genuinely large institutions.

The public health and hospital establishments recognized from the beginning that the suburbs required good community hospitals, preferably large hospitals. Initially the plan was to allow them to become respectable satellites to the core institutions; however, the movement of population to the suburbs resulted in a shift of bargaining power within the hospital establishment itself, with the consequence that many of these satellite community hospitals became regional centers in their own right. In the Detroit area, the four suburban hospitals authorized by the planning council (Oakwood, Beaumont, St. John, and Sinai) have since developed into tertiary care institutions.

64. The standards are set out in the 1961 MHS REPORT TO THE COMMR., *supra* note 56, at 18-20, 111-15. The standards, which were adopted by the Michigan Hospital Service Board of Trustees in January 1960, required that all participating hospitals maintain professional standards of operation appropriate to a general hospital, have an organized medical staff, meet all licensing and accreditation standards of the state, hold memberships in the appropriate national, state and local hospital councils and associations, and be accredited by the appropriate professional organizations. The Michigan Blue Cross enabling statute had restricted participating status to nonprofit hospitals; the 1960 standards required that the hospitals also be community sponsored and governed. Finally, the standards required that the hospitals "must have been planned and built in response to an established and recognized need for additional hospital beds" and that "the size of the hospital must be consistent with the needs of the community and must be large enough at an absolute minimum to insure that adequate levels of patient care can be maintained without prohibitive cost." *Id.* at 18-19.



— the smaller the cheaper.<sup>65</sup> Eliminating them would only force patients into larger hospitals with higher costs. Channeling new hospital construction into a regionalized pattern would necessarily lead to a more concentrated industry with fewer but larger hospitals,<sup>66</sup> thereby accelerating the rising trend of the costs billed to Blue Cross and intensifying the need for Blue Cross rate increases. Viewed as a cost control program, the Blue Cross standards were implausible.<sup>67</sup>

As we have seen, however, controlling cost was only one goal among many. Other goals of the hospital and public health establishments were to enhance quality and to improve access to service, and they were willing to tolerate rising costs attributable to rising quality or increasing utilization of services. They also believed that all hospitals within urban or base areas should conform to the evolving standards of elite medical practice, which required that they be large enough to support the administrative organization, patient services, and staff education functions that were regarded as the indicia of quality.<sup>68</sup> Bringing all hospitals up to these standards would

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65. Among Detroit area hospitals in 1958, the average cost per patient day of voluntary hospitals with fewer than 100 beds was \$27.15; the *per diem* cost in hospitals of 100-249 beds was \$31.71, for 250-499 beds \$33.99, and for hospitals of over 500 beds \$36.27. There were also fewer total beds in the smaller institutions. In the Detroit area, the 50 hospitals with 100 or fewer beds together accounted for only 2312 beds; the seven hospitals in the same area with more than 500 beds together accounted for 4741 beds, more than twice as many. It is (and was in 1958) well understood that hospital costs increase with the size of the hospital. See 2 W. MCNERNEY, *supra* note 50, at 731, 735.

66. As a conceptual guide to metropolitan hospital planning the idea of the tiered regional system was crude. Clearly it would make no sense to place a 500-bed hospital at the very periphery of a large metropolitan area. Within the denser parts of an urban area, however, there might be ample support for several hospitals of 200 or more beds. Some of these hospitals could be referral centers for sophisticated care; some or even most of them probably could be community hospitals. The concept of regional planning furnishes little guidance as to which hospitals should be allowed to grow into what we now call tertiary care facilities and which should be forced to remain as community hospitals. Moreover, the concept of regionalization does not address demographic shifts that produce new centers of gravity within a metropolitan area. Without violating any basic principles, therefore, all hospitals within urban or "base" areas were entitled to aspire to become referral centers. The only constraint on their aspirations was the idea of community "need," which was to be determined through voluntary planning.

In the absence of standards, however, collective "planning" degenerates into political bargaining. The natural tendency of the planning council to adjust ambitions among existing institutions was legitimized by the state Hill-Burton agency, whose policies for regional planning stated that, whenever feasible, existing hospitals should be expanded before new hospitals were built. See 2 W. MCNERNEY, *supra* note 50, at 1376.

67. Interestingly, the Michigan Hospital Service did not identify these measures as cost containment in its 1961 report to the Commissioner. See 1961 MHS REPORT TO THE COMM., *supra* note 56.

68. See JOINT COMMITTEE OF THE AMERICAN HOSPITAL ASSOCIATION AND PUBLIC HEALTH SERVICE, AREAWIDE PLANNING FOR HOSPITALS AND RELATED HEALTH FACILITIES 29 (1961). This report, which followed the 1959 conferences on regional planning sponsored jointly by the AHA and the PHS, became the single most influential document in the subsequent development of health planning.

be expensive; it was clear that successful regional planning would actually contribute to rising costs by raising both the quality and the amount of services consumed. Any "cost savings" attributable to regional planning would be due to the avoidance of "unnecessary" costs within an increasingly costly system.

In practice the Blue Cross standards for participating hospitals ensured that Blue Cross resources would flow exclusively into the larger voluntary hospitals, which would divide patients and markets among themselves through regional planning. Responsibility for determining community "need" under the Blue Cross standards was transferred to the Greater Detroit Area Hospital Council,<sup>69</sup> whose leadership was thoroughly committed to the program. The Council and the Blue Cross became the managers for what economists would describe as a cost-enhancing and quality-maintaining cartel.

This cartel formed in response to an economic threat peculiar to the hospital industry. Most industries that seek regulation do so in order to limit production in the face of excess capacity or to raise product standards in order to eliminate low-cost competitors. The hospital industry, however, was not suffering from excess capacity, and the smaller hospitals were not endangering the market shares of the larger hospitals.<sup>70</sup> The hospitals' problem was that the total amount of resources flowing into the industry was subject to political limitation. That amount could level off or even fall should state insurance commissioners become unwilling to approve frequent Blue Cross rate increases or the public lose trust in the ability of the voluntary hospitals to deliver high-quality care at a cost that was, all things considered, reasonable. Moreover, if hospital costs appeared to be both uncontrollable and unjustified, the government might seek direct control either by regulation or by subsidy in the form of government health insurance.

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69. The Detroit area hospital council had originally been composed entirely of hospital representatives, and had been called the Detroit District Hospital Council. In 1956, largely in response to the need to plan for suburban hospital development, the council had transformed itself into a community-based council renamed the Greater Detroit Area Hospital Council. See 2 W. MCNERNEY, *supra* note 50, at 1252, 1255.

70. The occupancy rates of the large hospitals were not falling as the small hospitals proliferated during the 1950s. The University of Michigan study team reported that the average occupancy rate for all nonfederal short-term general hospitals in the Southeastern Lower Michigan area (which includes Detroit) was 82 percent. The average occupancy rate in all hospitals over 250 beds was 84 percent; hospitals under 50 beds averaged 69 percent and those between 50 and 99 beds 76 percent. See 2 W. MCNERNEY, *supra* note 50, at 732. The low occupancy rates of the smaller hospitals were used as evidence that they were inefficient and should be eliminated. The fact that all hospital beds were not filled at all times does not indicate a lack of effective demand for hospital services. See discussion of Roemer's Law in Appendix II *infra*.

Blue Cross rate requests in the middle and late 1950s reopened the question whether the Blue Cross represented the interests of its own subscribers or whether it was bound completely to the hospital interest. Furor over the 1955 Michigan Blue Cross request for a twenty-five percent rate increase led Governor Williams to appoint a blue-ribbon investigatory commission; there was discussion of re-shaping the Blue Cross Board of Directors to provide for more public control.<sup>71</sup> Blue Cross was particularly vulnerable to public outrage because it was the creature of state enabling legislation. If the public lost faith in the ability or the willingness of the Blue Cross to represent the public interest vis-à-vis the hospitals, the legislature might simply revise the enabling statute to change the composition of the Board of Directors or to allow the government to set reimbursement policy.

The Blue Cross-GDAH program of eliminating the small hospitals and instituting controls over construction was meant to ward off government action by demonstrating voluntary collective self-discipline. The hospitals did not concede, however, that rising costs were the principal problem. The Blue Cross, the voluntary hospitals, and the public health establishment all believed that the real problem was that the public did not understand why hospital costs were rising and therefore did not trust the Blue Cross. The issue was legitimacy, not cost, and the hospital-Blue Cross response was designed to resurrect their legitimacy.<sup>72</sup>

The challenge was to gain public acceptance of rising health care costs. The voluntary hospital and public health establishments were

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71. See O. ANDERSON, *THE UNEASY EQUILIBRIUM* 167 (1968).

The Governor's Study Commission on Prepaid Hospital and Medical Care Plans (the Bowles Commission) engaged the University of Michigan study team, headed by Walter J. McNerney, director of the hospital and health administration program at the University of Michigan School of Business Administration, to conduct what turned into a six-year study of hospital economics. See W. MCNERNEY, *supra* note 50. The McNerney Report was used nationwide by the hospitals to explain the relationship between rising costs and quality. McNerney himself was a member of the AHA Council on Research and Education, and in 1961 became the executive director of the national Blue Cross Association.

72. In referring to the Blue Cross and the hospitals, we use the term "legitimacy" to mean any of the following depending on the context: (1) an absence of widespread political demand on the part of the middle classes for government health insurance, indicating satisfaction with voluntary health insurance; (2) public willingness to support the values of the elite hospital establishment against the leveling tendencies of government programs; (3) absence of political controversy over the performance of the Blue Cross and the hospitals or disquiet over their relationship; or (4) public acceptance of the decisions of the elite voluntary hospitals and the Blue Cross regarding the quality and organization of medical services.

In discussing certificate-of-need legislation with persons who participated in its development in New York, the authors were told several times that the purpose of CON was to restore the "legitimacy" of the Blue Cross. Dr. Ray Trussell told us that the reason why the Blue Cross could not institute controls over hospital construction was that the organization lacked "legitimacy."

persuaded that the public in fact desired high-quality hospital facilities and was willing to pay for them. Officials believed that if the public understood that recurrent Blue Cross rate increases were the result of the steadily increasing complexity and sophistication of medical services, there would be little public opposition. If the public believed that the voluntary hospitals were all of high quality and were managed efficiently it would understand that expensive hospital care still represented good value; if the public believed that the hospitals could discipline themselves through regional planning it would not call for government intervention.<sup>73</sup> Eliminating the small hospitals was explained by the need to ensure uniform high quality and efficient utilization of a regionalized hospital system;<sup>74</sup> planning was to be a demonstration of the hospitals' willingness to subordinate their individual interests to the good of the community.

Above all, the hospitals and the Blue Cross wanted to divert public attention from the issue of cost. They wanted the public to focus on the shape of the hospital system viewed as a whole, to participate in its design, and to share in the decisions that, given the public's appetite for quality medical care, would drive costs irresistibly upward. If regional planning had the participation of community leaders and therefore their imprimatur, the community would then be prepared to assume responsibility for the costs that followed from planning decisions. Public participation in the voluntary hospitals' own system of self-governance would simultaneously satisfy the public's need to believe that hospital planning decisions were being made in the public interest and end the clamor for government action.

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73. Michigan Blue Cross has repeatedly demonstrated that it can exist under reasonable controls and that, unlike many other agencies purporting to operate in the public interest, it can even flourish under self-controls that are planned and executed mutually with the community hospitals. This has been demonstrated even though there is no immediate prospect that the cost of health care in this country, or in this state, is going to level off or decrease. The structure of Blue Cross, with its roots in the local community and the community hospital, offers an effective and democratic system for keeping the cost of health care balanced properly with the rest of the economy.

1961 MHS REPORT TO THE COMM., *supra* note 56, at 7.

74. The public needed to be persuaded that rising hospital costs were justified by the rising quality of service as measured by elite standards of medical practice; the small hospitals did not represent those standards and did not share the values of the hospital establishment, which was based in the large hospitals. The smaller hospitals had fewer specialists on their staffs, delivered fewer services per bed and generally did not use the full range of techniques of hospital administration that had been adopted by the hospital establishment as standard indicia of quality. They also lagged behind the large hospitals in the introduction of new technology. See L. RUSSELL, *TECHNOLOGY IN HOSPITALS* 71-98 (1979). Their presence in the hospital system would therefore make it difficult for the Blue Cross to justify its rising rates. The presence of small hospitals in large urban areas was also theoretically inconsistent with the tiered regional hospital model, which called for centralization of hospital resources wherever larger institutions were economically feasible.

Controversy over Blue Cross rate increases was also erupting in other states with large Blue Cross plans. Insurance commissioners in Maryland, Pennsylvania, New Jersey, Massachusetts, and New York were becoming restive as Blue Cross plans barraged them with requests for rate increases.<sup>75</sup> In 1958 the Pennsylvania Insurance Commissioner denied rate increases for three Pennsylvania Blue Cross plans. He found that Blue Cross benefits had been abused by unnecessary utilization of hospital services in the form of unjustified admissions and protracted hospital stays. He further accused the hospitals of doing very little to bring about efficient and economical management. The Commissioner's decision rested, however, on the more dangerous premise that the Blue Cross was tied too closely to the hospitals and could not protect its subscribers' interests without assistance from the government. His order required the Blue Cross to develop utilization controls and other management improvement techniques; hospitals were required to adopt these measures or face the Commissioner's disapproval of their Blue Cross reimbursement contracts.<sup>76</sup>

The Pennsylvania decision threatened to force the Blue Cross into a collaboration with the insurance commissioner to contain costs and to oversee the management of the hospital system. If the decision were to be replicated widely, the Blue Cross would become virtually an arm of the government. It now became urgent for the voluntary hospitals and the Blue Cross to regain public confidence: these doubts about the ability of the Blue Cross to protect the public's interest in affordable health insurance were arising just as the aged were turning to the federal government for assistance in coping with the rising cost of health care<sup>77</sup> and therefore reviving the na-

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75. See O. ANDERSON, *supra* note 71, at 167-68.

76. See *Abstract of the Adjudication of Pennsylvania Insurance Commissioner Francis R. Smith*, HOSPITALS, May 16, 1958, at 101, 116-25. The order also stated that (1) future Blue Cross reimbursement formulas must pass through to subscribers the cost savings attributable to the required management improvements; (2) hospitals must fund depreciation allowances if they are reimbursed for depreciation expense under Blue Cross contracts; (3) Blue Cross must not reimburse for costs resulting from the construction of new plant or the cost of free care, and should adjust its share of reimbursement of the costs of maintaining nursing schools or carrying out medical research to reflect the services received by Blue Cross patients from such programs; (4) in all negotiations between Blue Cross and the hospitals, the Blue Cross negotiators must be persons who lack official connection with hospital administration so that they represent solely the interest of Blue Cross subscribers. The Commissioner also disapproved of the Blue Cross practice of offering experience-based rates to employee groups in order to meet competition from commercial insurance companies. He announced his intention to disapprove commercial health insurance rates where commercial insurance companies were selling health insurance at below cost in order to obtain customers for life insurance.

77. See J. SUNDQUIST, *POLITICS AND POLICY* 287-321 (1968), for an account of the political forces that brought about the passage of the Medicare and Medicaid programs, which provide federal funds for health care for the elderly and the indigent.

tional debate over compulsory government health insurance.

Regional planning, which offered a solution to the threat of explosive suburban growth, also made it possible for the voluntary hospitals and the Blue Cross to deflect public pressure for cost containment by redefining the problem. The public believed that hospital costs were too high; the hospitals, supported by the public health establishment, argued that they were, if anything, too low if the public wanted high-quality care and did not want to underpay hospital employees, who were already at the bottom of the wage scale.<sup>78</sup> The public believed that hospital facilities were overutilized because of health insurance; the hospitals and the public health schools argued that overutilization was a minor problem that could be solved responsibly only by self-governance on the part of hospitals and attending physicians who were sensitive to the imperatives of good medical practice.<sup>79</sup>

The hospital and public health establishments encouraged the public to criticize inefficient utilization of hospital services. Approximately twenty-six percent of the beds in the hospital system were vacant at any given moment. According to the voluntary hospitals, empty beds, not overutilization, were the problem. They argued that the system must be designed to prevent the building of too many hospital beds, that any new beds must be in larger, more efficient hospitals, and that the small hospitals, whose occupancy rates were the lowest, must be closed.<sup>80</sup> In essence, the argument was that if the hospital system would use its invested capital more intensively, it could eliminate unnecessary costs while maintaining the quality of care. The solution to the cost problem, then, was control of hospital construction. It would best be carried out by voluntary planning agencies, but if the public insisted on some government control over the hospital system, the proper mechanism would be hospital construction licensing, known today as certificate-of-need.

The idea of certificate-of-need was developed to provide an outlet for public frustration over hospital costs while avoiding cost control. Dr. Ray E. Brown, the person credited with inventing CON, clearly stated his intentions:

If there is to be public regulation of the voluntary hospital system, state franchising offers the best means of accomplishing the ends sought and

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78. See 2 W. MCNERNEY, *supra* note 50, at 756-821; TRUSSELL REPORT, *supra* note 62, at 3.

79. See 1 W. MCNERNEY, *supra* note 50, at 471-94; TRUSSELL REPORT, *supra* note 62, at 226.

80. See Brown, *Let the Public Control Utilization Through Planning*, HOSPITALS, Dec. 1, 1959, at 34-39, 108-10.

does least damage to the values of the voluntary system. It is a means for the public to control itself by controlling the manner in which it builds and uses its hospitals.

The idea of governmental control in any form is repugnant to all of us who are dedicated to the voluntary way of life and our voluntary system of hospitals. We realize the dangers of capricious actions by legal agencies and the ease with which political expediency can supplant logic in governmental decisions. However, the right of the public to impose such controls is unquestioned. They are already being imposed increasingly by insurance commissions.

However, those controls could wreck the voluntary hospital system because they control cost, and cost controls quickly and inevitably become controls of quality. The public must understand that it cannot retain freedom of use of its hospitals and impose controls on the cost of its prepayment at the same time. Control through planning offers the public and its voluntary hospital system an alternative that best protects both.<sup>81</sup>

Avoiding cost control by inviting the government to control hospital construction was not necessary in states like Michigan where the Blue Cross and the hospitals could undertake such a program using existing voluntary agencies.<sup>82</sup> But faced with the volatile political environment of New York State, the Blue Cross and the hospital establishment turned to government licensing of hospital construction to put "teeth" into their own regional planning process. Because public controversy had been stimulated by the issue of hospital costs, however, the program had to be presented not as a way of avoiding cost controls but as a form of cost control. To meet this need, the expectation was generated that certificate-of-need regulation would do what it was neither designed nor intended to do (and what, given the premises of regional planning, it could not be expected to do): moderate the rising trend of hospital costs.

## V. NEW YORK AND THE CERTIFICATE-OF-NEED MYTH

The reasoning that led the New York hospital and public health establishments to propose certificate-of-need legislation was set out in a document entitled *Prepayment for Hospital Care in New York: A Report on the Eight Blue Cross Plans Serving New York Residents*,

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81. *Id.* at 110.

82. The Michigan Blue Cross offered construction controls as part of a package of actions designed to control costs, including ceilings on cost increases in reimbursement formulas geared to hospital size. See 1961 MHS REPORT TO THE COMMR., *supra* note 56, at 66-68; 2 W. MCNERNEY, *supra* note 50, at 976-80. The idea of using Blue Cross reimbursement formulas as a cost containment mechanism was expressly disapproved in the TRUSSELL REPORT, *supra* note 62, at 10.

known popularly as the Trussell Report.<sup>83</sup> The Trussell Report had been commissioned by the New York State Superintendent of Insurance and the Commissioner of Health after they discovered that the testimony of the witnesses in hearings on Blue Cross requests for rate increases in 1958 was distinguished by conflict, confusion, and lack of information. The report was to consist of "an extensive review of the entire nonprofit prepayment movement in the State."<sup>84</sup>

At the time the report was commissioned, it was widely believed that excess hospital utilization was the major cause of hospital cost inflation. The charge to the Trussell study team reflects that view. The team was asked to evaluate whether there was need of an independent regulatory body to review utilization decisions, suggesting that the state authorities were at least considering the possibility of significant intervention in the internal affairs of the hospitals.<sup>85</sup>

When the Trussell Report was submitted in 1960, however, the idea of independent utilization controls had been quietly dropped. Instead, the report reflected the resistance of the hospital establishment to cost controls. The report did not accept cost containment as a legitimate foundation of public policy toward hospitals, did not focus on measures to reduce costs, and did not suggest that controls on hospital construction, which it recommended, were to be considered a method of cost control. In the introductory section of the report the study team took the position that

[r]ising costs have been accompanied by rate increases to subscribers. . . . Due to the erosion of reserves [as a result of Department of Insurance attempts to hold back rate increases] it becomes evident that Blue Cross contracts have been *underpriced*. The public also has been

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83. See TRUSSELL REPORT, *supra* note 62.

84. *Id.* at 11.

Failing to obtain appropriations from the Legislature to support the study, the Commissioner of Insurance asked each of the Blue Cross plans to contribute to the cost, which came to \$150,000. The final report was thus a Blue Cross-financed document.

Dr. Trussell, the leader of the study team, was a medical doctor with a degree in public health and Chairman of the Columbia University Department of Public Health and Administrative Medicine. The associate director of the study was Frank Van Dyke, the Blue Cross pioneer who had founded the Essex County hospital service plan. The various advisory committees that were associated with the project reflected faithfully the major constituencies of the Blue Cross: the non-profit hospitals (only one person affiliated with proprietary hospitals appears on the committee list); the doctors (including the immediate past president, the current president and the president-elect of the New York State Medical Society); pre-payment plan executives, principally Blue Cross and Blue Shield; representatives of business and major labor organizations. The Trussell Report can most realistically be viewed not as an independent study conducted by an impartial outside agency but as an exercise in self-study and self-criticism conducted from the inside. The report virtually ignores the specific questions asked by the Superintendent of Insurance, which, if addressed squarely, would have required a fresh look at the structure of the hospital industry and a reexamination of Blue Cross reimbursement practices.

85. See TRUSSELL REPORT, *supra* note 62, at 11-12.



receiving care subsidized by underpaid hospital personnel. In addition, some hospitals have not been able to provide optimum services to the public because Blue Cross payments to them have been less than the cost of providing care or insufficient to permit development of new services. The public is the long range loser when it underpays its good hospitals.<sup>86</sup>

Most of the study team's recommendations had to do with the creation of provider-dominated, community-based regional hospital planning councils, to which all proposals for hospital construction or expansion were to be submitted. The report recommended that facilities not be licensed or financed by the state or reimbursed by Blue Cross unless they met the criteria set forth in regional master plans to be developed by the councils.

The Trussell Report sought to allay any fear that it was proposing that the government actually control the hospitals:

The purpose of the foregoing recommendations is not to create governmental control and bureaucracy but to fix responsibility on the professions and their organizations to carry out functions locally which are important but only partially performed at present. . . . Paid personnel are . . . working in most regions for the various organizations and the proposal need not involve the addition of very many people in or-

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86. *Id.* at 3.

The Trussell Report acknowledged that the great increase in hospital costs was to be found in rising costs per patient day, which in turn reflected the increasing cost and quality of services rendered, chiefly professional and technical services. Moreover, it found that the "ratio of employees per bed has been rising in the past decade with the growing complexity of patient care and is higher in the larger hospitals studied." *Id.* at 158. The study showed "several definite relationships" between the educational activities of general hospitals and their higher *per diem* costs. *Id.* at 59. The study concluded that

Costs in the State as a whole go up steadily with size and (once 50 percent occupancy has been reached) also go up with occupancy. The costly quality differences associated with hospitals of greater size and occupancy help provide an explanation of this trend. What is evident in this study is that the complexity and quality of services rendered and functions performed increase as size and occupancy rise and these tend to offset any economies (division of labor, etc.) associated with the greater scale of operations and fuller use of personnel and plant.

*Id.* at 159.

Turning to the question of hospital utilization, the study found no significant differences between Blue Cross subscribers and patients with other means of payment reflected in utilization of tests and other ancillary facilities, or in length of stay. It did find, however, that "the average length of stay can be seen to progress with increases in size of the hospitals." *Id.* at 226. It also found that "the average length of stay in proprietary hospitals is substantially less than that of the other types of hospitals included in this study." *Id.*

Although the recommendations that deal with reimbursement formulas implicitly exclude the possibility of using reimbursement policy as a method of controlling costs, *see* TRUSSELL REPORT, *supra* note 62, at 9, the problem of cost is not overlooked completely: it is treated as a problem in public relations and an area for further research. The study team reported that "hospital costs will continue to increase and the public is entitled to know that [not, apparently, *whether*] such costs are justifiable." *Id.* at 8. The study team suggested that there be a "coordinated regional program for the collection, analysis and interpretation of data pertaining to hospital patient care and financial operations." This data to be disseminated to "interested agencies." *Id.* at 8.

der to accomplish what can be one of the most important health programs ever to be undertaken.<sup>87</sup>

This recommendation became, with some minor modification during the legislative process, the basis of the 1964 Metcalf-McCloskey Act — New York's certificate-of-need law.

The Trussell Report recommendations first came to public attention in an atmosphere of political acrimony over Blue Cross rate increases and amid calls for legislative intervention on behalf of ratepayers. In response to the 1958 rate request the Insurance Commissioner had authorized increases averaging 33.45 percent, to become effective in November 1960.<sup>88</sup> The predictably adverse effect of this increase on Blue Cross's relations with the public were exacerbated in December 1960 when the Associated Hospital Service of New York gave its employees salary increases and annual length-of-service adjustments, unfortunately packaged as "Christmas bonuses." Assemblyman Lucian F. Russo, Vice-Chairman of the Joint Legislative Committee, made a political issue of the bonuses and the rate increase, vowing his "entire energies at the next session of the Legislature . . . to correcting this situation which, in the last analysis reposes with elected public officials."<sup>89</sup> Assemblyman Russo and Democratic State Chairman Prendergast demanded an investigation of the Blue Cross by an Assembly Committee. The issue took on a partisan dimension: the Democrats accused the Rockefeller Administration of sacrificing the interests of working class ratepayers to those of the Blue Cross and the hospitals.<sup>90</sup> Meanwhile, Senator George R. Metcalf had been active in placing the Trussell Report recommendations on the legislative agenda of the Joint Legislative Committee on Health Insurance Plans, which he chaired.

It was clear to all informed parties that the Christmas bonus problem was a red herring: the salary increases were routine and Blue Cross administrative costs were modest.<sup>91</sup> The combination of the rate increase and the bonus problem had called into question, however, the legitimacy of the Blue Cross as a public service institution, and there was considerable pressure on the legislature to intervene. In response, the Blue Cross and its allies promoted implementation of the Trussell Report recommendations, which

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87. TRUSSELL REPORT, *supra* note 62, at 6.

88. See 1961 JT. COMM. REPORT, *supra* note 39, at 20.

89. *Id.*

90. See N.Y. Times, Feb. 1, 1961, at 37, col. 8.

91. See 1961 JT. COMM. REPORT, *supra* note 39, at 23-24.

could satisfy the perceived need for public action while not threatening the interests of the Blue Cross or the major hospitals.

Senator Metcalf was an early sponsor of legislation implementing the major Trussell Report recommendation.<sup>92</sup> His strategy was to hold regional hearings on the Blue Cross in order to reassure the public of the basic integrity of the Blue Cross organization and at the same time to press for mandatory regional planning and CON.<sup>93</sup> He also advocated greater community representation on Blue Cross boards of directors, and he explicitly encouraged representation of organized labor, which both supported CON and wanted a more prominent voice in health affairs.

Senator Metcalf's legislative leadership in the public sector was complemented in the Blue Cross-hospital arena by that of J. Douglas Colman, President of the Associated Hospital Service of New York, the single largest Blue Cross plan in the nation.<sup>94</sup> Colman put his personal authority and that of the Blue Cross behind the proposition that CON would control hospital costs and help to stem the rise of Blue Cross rates.

The Trussell Report had not made the case for CON as a solution to the hospital cost and Blue Cross rate increase problem. In-

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92. Senator Metcalf's activities in developing certificate-of-need legislation were consistent with his pattern of promoting moderately progressive reform measures to prod the health establishment into meeting new demands for health services in order to avoid more intensive government action that might lead to what was then called "socialized medicine." During 1961-1964 when he was advocating CON controls, for example, the reports of the Joint Committee on Health Insurance Plans indicate that he was working actively on government support of medical care for the aged, mandatory hospitalization insurance for employees covered by disability insurance, and improved services for alcoholism, drug addiction and mental illness, among other items. On several of these programs he enjoyed the collaboration of the Columbia University School of Public Health.

93. The New York State Legislature does not maintain full legislative histories. Our account of the development of the CON law, popularly known as the Metcalf-McCloskey Act, is based on the annual reports of the Joint Legislative Committee on Health Insurance Plans for the years 1961-1964. See 1961 JT. COMM. REPORT, *supra* note 39; NEW YORK JOINT LEGISLATIVE COMMITTEE, REPORT ON HEALTH INSURANCE PLANS, Legislative Doc. No. 16 (1962) [hereinafter cited as 1962 JT. COMM. REPORT]; NEW YORK JOINT LEGISLATIVE COMMITTEE, REPORT ON HEALTH INSURANCE PLANS, Legislative Doc. No. 21 (1963) [hereinafter cited as 1963 JT. COMM. REPORT]; NEW YORK JOINT LEGISLATIVE COMMITTEE, REPORT ON HEALTH INSURANCE PLANS, Legislative Doc. No. 39 (1964) [hereinafter cited as 1964 JT. COMM. REPORT].

94. Colman had assumed the presidency of the Associated Hospital Service in April 1960. Prior to that time he had been vice-president and secretary of the Blue Cross Association. He was also an authentic Blue Cross pioneer, having served as executive secretary of the Essex County plan in the late 1930s, leaving it in order to found the Maryland Blue Cross and Blue Shield plans. His academic credentials were impressive. He had been on the faculty of Johns Hopkins for 16 years and had served as vice-president of the university and hospital in charge of its development program. See N.Y. Times, Dec. 9, 1972, at 38, col. 2. Colman chaired the special committee that worked out the details of CON legislation among interested parties. See 1962 JT. COMM. REPORT, *supra* note 93, at 130.

deed, the study team had taken the position that the rise in hospital costs and therefore Blue Cross rates was due principally to the high quality of care provided in the good hospitals. The only even marginally respectable intellectual justification for making the connection between capacity controls and Blue Cross rate increases rested on a misinterpretation of a theory of hospital economics known as Roemer's Law. Milton Roemer of the Cornell School of Hospital Administration had theorized that under conditions of widespread health insurance a population will use as many hospital beds as are made available to it.<sup>95</sup> His argument quickly became identified with the proposition that controlling hospital construction will control costs. Dr. Roemer himself attempted to correct the error by pointing out to the Joint Committee that regulating hospital construction would not necessarily lead to a diminution in the rate of increase in hospital costs and might even have the opposite effect.<sup>96</sup> Undaunted, Colman pressed urgently for enactment of the program, asserting authoritatively that construction controls would constrain Blue Cross rate increases and that failure to enact CON would lead to continued escalation of premiums.

The other principal institutional promoter of the legislation was the New York State Department of Health. The Health Department, which was a leader in the public health establishment nationally, shared the belief that regional planning and hospital construction controls were the appropriate regulatory response to the Blue Cross crisis and were desirable even apart from that crisis. As an arm of the state government, however, it had more complex interests. Its own organizational objective was to consolidate its control over all health activities, ending the role of the State Department of Social Welfare in licensing health facilities. Its role as friendly regulator in overseeing the regional planning and CON process would also transfer principal responsibility for hospital cost control measures from the Insurance Commissioner to public health officials.

The Health Department had several complementary reasons for

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95. See Appendix II for a discussion of Roemer's Law.

96. Roemer addressed the question squarely in his testimony before the New York Joint Legislative Committee on Health Insurance Plans:

Basically the rise in the cost of hospital care in the past twenty-five years . . . has not been due to the utilization rate. The utilization rate in hospitals, in fact, in terms of days of care provided has been surprisingly small. Over the last thirty years, there has been a rise in the days of hospital care for size of population of only about twenty percent. There has been a rise in the daily cost of hospital care of about 400 or 500 percent. If you worked out the arithmetic of this you would find that the cost to a community of the operation of its hospitals is higher today because the rise is roughly ninety-five percent due to the cost of better care and only five percent due to a rise in utilization rate.

1962 JT. COMM. REPORT, *supra* note 93, at 92.

wanting to protect the large downtown teaching hospitals and to control capital formation in the suburbs. It of course desired to protect the primacy of the large teaching hospitals within the health care system, particularly in New York City. As an arm of the state government it was also concerned that the existing voluntary hospitals be able to maintain themselves as an important local industry employing large numbers of workers. In addition, the voluntary hospitals were performing an essential public function. They were not ordinary business firms: if they were threatened financially the government would probably have to support them; if they perished, the government would have to perform their functions. Although it is accurate to observe that the voluntary hospital establishment in New York sought state government regulation because the Blue Cross had been disabled politically from performing the function of cartel manager, it is important to understand that the government in general and the state health department in particular had an independent interest in supporting the cartel. All these interests converged to produce close cooperation between the hospitals and state public health officials in the campaign for regional planning and CON legislation.

Certificate-of-need legislation was enacted in New York without real controversy; the time that elapsed between the publication of the Trussell Report and the passage of the Metcalf-McCloskey Act was devoted principally to negotiations over the degree of government control of the planning process,<sup>97</sup> over whether the denominational hospitals were to be evaluated separately,<sup>98</sup> and over whether government (including university) hospitals were to be controlled under the program. These issues were all negotiated within the voluntary hospital and public health establishment, which included the state Department of Health.

The leaders of the voluntary hospitals, the public health establishment, and the Blue Cross all wanted to see the CON program enacted. They obviously lacked incentives to point out to the legislature the error of assuming that CON would control costs. Even Roemer, who clearly understood that CON was not cost control,

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97. Dr. Herman E. Hilleboe, New York State Commissioner of Health, took an active part in shaping the *Trussell Report* recommendations and CON legislation. Dr. Hilleboe later joined the faculty of Columbia University School of Public Health and Administrative Medicine. The authors wish to thank Dr. Andrew C. Fleck of the New York State Department of Health for providing insight into the governmental interest in CON.

98. The Catholic hospitals wanted the hospital needs of religious denominations to be evaluated separately from the general community need; such a provision, although opposed by other parties, was incorporated in the legislation. See 1964 JT. COMM. REPORT, *supra* note 93, at 86.

supported it as a first step toward government control over hospitals. Senator Metcalf was bent primarily on reviving public trust in the Blue Cross and the voluntary hospital system, not on containing hospital costs; regional planning and CON were consonant with his objectives and were politically feasible as well. He had no reason to cast doubt on the program that he was sponsoring. That CON would not control costs could have been deduced, however, by anyone who cared to apply elementary economic analysis to the hospitals. That CON was not attacked as being inadequate to control costs suggests that even the most severe critics of the hospitals and the Blue Cross were not committed single-mindedly to cost containment.

In New York as elsewhere, it was organized labor that objected most strongly to rising Blue Cross rates. The unions were ambivalent adversaries of the hospital establishment. In the end, however, they generally supported hospital planning and CON. The reason lies in the apparent relationship, between quality and cost, insisted upon by the hospitals. The unions were interested in holding down the cost of care, but they were also concerned with the quality of care their members received. Planning and CON promised to produce high quality care at the lowest achievable cost; the unions would have been reluctant to press for actual cost containment if it might threaten the quality of care.<sup>99</sup>

While there was no clear constituency for government regulation of hospital costs, the idea of government control over the construction of health care facilities appealed both to those who desired to protect or oversee the existing voluntary hospitals and to those who were disturbed by the growth of proprietary health care facilities. The clearest targets of CON regulations were the small hospitals located in the suburbs, many of which were proprietary. While proprietary hospitals in New York City could not be built without the permission of the New York City Commissioner of Hospitals, there was no equivalent local regulation in Nassau or Suffolk County.<sup>100</sup>

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99. In New York the most vocal union was the Teamsters, who threatened to set up their own system of hospitals. They were dissuaded from this plan after they were given a short course in the complexities of health care delivery. The course was arranged by Douglas Colman and Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals.

100. The problem of the proprietaries was localized in the Greater New York area: while only one other Blue Cross plan had as many as two proprietary hospitals within its service area, the New York City plan had 53. New York's Blue Cross enabling legislation, unlike Michigan's, did not bar proprietary hospitals from participating status. There were 72 hospitals with fewer than 100 beds that held participating status in the New York City Blue Cross, of which 32 were proprietary; and 58 hospitals with between 100 and 200 beds, of which 21 were proprietary. See TRUSSELL REPORT, *supra* note 62, at 265. Nearly all of the smallest

Construction of voluntary hospitals had lagged behind population growth in these areas: capital formation for voluntary hospitals, particularly large ones, requires community-wide solicitations for funds based on perceived need. By contrast, a corporation or a group of individual physicians can raise enough capital to build a simple facility with fewer than 100 beds. Proprietary hospitals in the suburbs threatened to satisfy the burgeoning demand for services, potentially frustrating the orderly development of a regionalized system of non-profit hospitals.

As we have seen, the public health and hospital establishments were hostile to all small hospitals, whether nonprofit or proprietary. In addition, they were hostile to proprietary hospitals of any size. In New York, many of the smallest hospitals were proprietary, giving the proponents of CON an opportunity to focus legislators' attention on their for-profit status, which, in a world of health care dominated by nonprofit community-based organizations, made them disreputable.

The problem of controlling the proprietaries was the dominant theme of the deliberations on CON legislation from the first Joint Committee meeting on the Trussell Report in January 1961 right down through passage of the Metcalf-McCloskey Act in April 1964. In that first meeting Dr. Trussell inaugurated the strategy of linking the existence of proprietaries to the problem of rising Blue Cross rates.

There seem to be legal problems in controlling proprietary hospitals which are apparently conceived as extensions of the doctor's office and therefore not subject to limitation. New York City's Blue Cross plan is concerned at the number of proprietary hospitals being built in Nassau County. Five are presently under construction or being promoted. All are outside the City limits. There seems to be no liaison between the Department of Social Welfare and Blue Cross on this matter. Yet Blue Cross absorbs the burden of reimbursing these hospitals

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hospitals, most of which were proprietaries, were unaccredited by the Joint Commission on Accreditation of Hospitals.

The Joint Commission on Accreditation of Hospitals (JCAH) had been formed in 1951, financed by the American Hospital Association, American Medical Association, American College of Surgeons, American College of Physicians, and the Canadian Medical Association (which withdrew in 1958 to form a separate national program). The JCAH standards principally concern the administrative organization of the hospital and the provision of certain services; they govern condition of the physical plant, governing board responsibilities, and essential services. Complying with these standards is relatively expensive and raises the amount of administrative effort required for the management of a hospital. The standards are based on administrative practices established by larger institutions, and it was rare by 1958 to find a large hospital that was not either accredited or on the verge of becoming accredited. The incidence of accreditation fell with declining hospital size. See 2 W. MCNERNEY, *supra* note 50, at 809; TRUSSELL REPORT, *supra* note 62, at 265.

and must ask the community for rate increases which are at least partially necessary because of this increase in the number of hospital beds.<sup>101</sup>

Stressing the impact of the proprietaries on Blue Cross rates reinforced the legislators' own unease with an unregulated environment. Senator Thaler, for example, had clear views on the subject of proprietaries:

As a member of this [joint] committee I have frequently heard accusations against proprietary hospitals specifically, in regard to unnecessary operations, overutilization, etc. This is entirely apart from the fact that many of them constitute, by their method of operation, a serious economic problem for the voluntary and governmental hospitals. We have, in the New York City area, a scandal of the greatest proportions.<sup>102</sup>

The fact that so many of the smaller hospitals were unaccredited or proprietary or both made it possible for political concern over rising Blue Cross rates<sup>103</sup> and general public anxiety over the quality of care in proprietary facilities<sup>104</sup> to be fused into support for a single program that could be described as control of the proprietaries. The small hospitals' objections lacked credibility: they had no alternative solution to the cost problem; as proprietaries many of them were tarnished with the profit motive; and they were opposing a coherent, comprehensive idea of regionalization that was supported by all of the respectable institutions that dealt with health care matters.

The principal contemporary justification for CON, however, as articulated by its sponsors, was that it would control hospital costs. Attacking the proprietaries on the basis of both cost and quality helped to focus political support for the CON legislation. Senator Metcalf's press release announcing introduction of the 1964 bill that became the Metcalf-McCloskey Act described the program as being urgently sought by Blue Cross plans throughout the State because of their responsibility as wholesale purchasers of hospital care for their subscribers.

. . . .

Hospital authorities — including Senator Metcalf — are concerned that unless the minimal control over new bed construction such as that outlined for New York State in his bill becomes effective, the cost of hospital care may rise beyond the ability of many patients to afford it. . . . They feel, too, that Blue Cross premium rate raises, probably

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101. 1961 JT. COMM. REPORT, *supra* note 39, at 50.

102. 1964 JT. COMM. REPORT, *supra* note 93, at 73.

103. See TRUSSELL REPORT, *supra* note 62, at 262 (in New York City, proprietary unaccredited hospitals received 12 per cent of the total annual Blue Cross payments).

104. See 1962 JT. COMM. REPORT, *supra* note 93, at 108-10. The Associated Hospital Service had begun to deny participating status to unaccredited hospitals in 1960.



necessary soon in some areas because of increased hospital costs already in effect, may have to be so sharp as to threaten the structure of this non-profit community mechanism.<sup>105</sup>

The clear implication was that if the bill were passed costs and Blue Cross rates would not rise so sharply.

The Metcalf-McCloskey Act was passed in 1964, setting the legislative model for certificate-of-need statutes. Its pattern of relationships between state government and voluntary regional planning agencies has been copied widely.<sup>106</sup> Immediately after passage of the Metcalf-McCloskey Act, Governor Rockefeller appointed another study commission (the Folsom Committee), which recommended consolidating state control over health facilities construction in the Health Department.<sup>107</sup>

### EPILOGUE

The development of New York's certificate-of-need legislation spanned the period from the beginning of the joint AHA-USPHS promotion of areawide planning to the advent of Medicare and Medicaid. In 1958, when the Trussell Report was commissioned, the idea of government regulation of hospital construction as an alternative to cost containment had only just been advanced; by the time the Folsom Committee issued its final report in 1965 there was general agreement within the hospital and public health establishments that growing government supervision of hospitals, which was inevitable, should be channeled through areawide planning agencies that would function as part of the voluntary hospital system. In 1961 the

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105. 1964 JT. COMM. REPORT, *supra* note 93, at 99-100.

106. The act was modified slightly in 1965 by Article 28 of the New York Public Health Law, which was enacted on the basis of the preliminary report of the Folsom Committee. *See* note 107 *infra*. The two acts taken together required all hospital and nursing home construction (including renovation) to be approved by the State Health Department (except in New York City, where the New York Commissioner of Hospitals exercised the licensing function). The acts created a State Hospital Review and Planning Council with 31 members appointed by the Governor, of which not more than 15 could be health care providers, defined as physicians or employees of hospitals or nursing homes. The Council advised the licensing agencies. The principal responsibility for planning, however, lay with the regional councils, which were community-based, nongovernmental agencies. These agencies reviewed plans in the first instance and recommended approval or disapproval. The licensing agency then determined whether there was public need for the construction. *See* N.Y. PUBLIC HEALTH LAW Art. 28, § 2802 (McKinney), 1965 N.Y. Laws Ch. 795; 1964 N.Y. Laws Ch. 730.

107. *See* STATE OF NEW YORK GOVERNOR'S COMMITTEE ON HOSPITAL COSTS, REPORT 86-88 (1965). The committee was chaired by Marion B. Folsom, the former Secretary of HEW, who was closely associated with the Rochester Regional Planning Council. The executive director of the study team was made available to the committee by the Columbia University School of Public Health and Administrative Medicine. The list of contributors to the report substantially replicates the list of persons who were active in shaping the Metcalf-McCloskey Act. *See id.* at ii.

United States Public Health Service began disbursing grants to area-wide planning groups under the Community Health Services and Facilities Act of 1961.<sup>108</sup> In 1964 the Hill-Harris<sup>109</sup> amendments to the Hill-Burton Act provided additional funds for planning and enabled the USPHS to fund new planning agencies.

The New York certificate-of-need law operated largely as intended throughout the late 1960s. The net result of the program was to reduce the rate of increase in the number of hospital beds in metropolitan areas, particularly in the suburbs, and to accelerate the trend toward fewer but larger and more capital-intensive hospitals.<sup>110</sup> Most importantly, perhaps, the New York experience with CON demonstrated to the national hospital establishment that the friendly regulatory scheme envisioned by the leaders of the hospital and public health establishments could in fact operate to reinforce voluntary planning controls without compromising the autonomy of the hospitals or jeopardizing their essential interests. This demonstration was helpful in the subsequent nationwide diffusion of CON regulation as the hospital cost inflation of the 1960s made some form of government regulation of hospitals inevitable.

Passage of federal Medicare and Medicaid legislation in 1965 was a watershed in the developing relationship between government and the hospitals. Suddenly the market for health services became flooded with elderly and poor patients. Hospital costs skyrocketed. Superficially, the cost crisis of the late 1960s could be regarded as a more intense version of the problems of the late 1950s, which likewise had stemmed from an inflationary demand for hospital services stimulated by third-party payment. In the 1950s government had been a bystander in what was principally a private sector problem, taking the position that voluntary sector self-discipline was preferable to government intervention. Medicare and Medicaid had brought on a near-crisis in public finance, however, as governments at all levels watched their treasuries empty due to required reimbursement payments to health care providers. Government now had the need and the desire to act, driven by its own self-interest as a major purchaser of medical services. Like the Blue Cross in the late

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108. Community Health Services and Facilities Act of 1961, Pub. L. No. 87-395, 75 Stat. 824 (1961) (codified in scattered sections of 42 U.S.C.).

109. Hospital and Medical Facilities Amendment of 1964, Pub. L. No. 88-443, 78 Stat. 447 (1964).

110. *See generally* E. ROTHENBERG, REGULATION AND EXPANSION OF HEALTH FACILITIES (1976).

1950s its principal interest was in containing its own financial liabilities.

In the late 1960s, areawide planning and hospital construction controls were ascendant among health care experts of nearly all persuasions in both the public and the private sectors; the idea that planning could control costs was an article of faith even though evidence to support the belief was at best anecdotal.<sup>111</sup> With the new infusion of public resources into health care it seemed plausible that hospitals would indulge in unjustifiable duplication of equipment, facilities and services if they were not restrained from doing so; planning seemed to be the answer. Moreover, as the health care system had grown, so had perceptions of gaps in service, overutilization of expensive acute inpatient facilities, undersupply of out-patient and chronic care facilities, underemphasis on preventive care, and other mismatches between resources and needs. Areawide planning was touted as a method of creating a total health care system that would deliver services efficiently and thereby conserve resources.

The federal government took an active role in promoting the passage of state planning and CON legislation. By the mid-1960s the federal government had created a great number of health-oriented categorical grant programs, many of which provided federal funds directly to local governments and private organizations. State health officials complained of the proliferation of these narrow programs that bypassed state authority. In response, the Johnson Administration proposed to consolidate the grant programs into a single block grant that would enhance the health planning capabilities of state governments and encourage comprehensive health planning at regional or local levels. This approach was embodied in the Comprehensive Health Planning Act of 1966.<sup>112</sup>

It was clear when the 1966 act was passed that the state and regional health planning agencies were expected to disseminate the AHA-USPHS concepts of areawide planning and controls over health facilities construction. The regional agencies established under the act were modeled on existing voluntary hospital planning councils. They were required to have a fifty-one percent nonprovider majority, thus ensuring their base in the community; and they were to obtain half of their funding from local sources. In most cases

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111. The anecdotes were not supported by the evidence. May found in his 1967 study that the rate of increase in hospital costs per patient day in areas with planning agencies was higher than in areas without planning. J. MAY, *supra* note 44, at 71-72.

112. Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180 (codified at 42 U.S.C. § 246 (1976)).

the agencies obtained their local funds from hospital associations, medical societies, health and welfare councils, and other private organizations whose activities they were charged with coordinating. The planning agencies were typically created as private nonprofit corporations. They derived no regulatory authority from federal law and, prior to the enactment of state CON legislation, typically had none from the states.

Beginning in 1967 the federal government began to encourage states to use these agencies to regulate hospital construction. In that year it submitted legislation that would allow it to enter into agreements with states under which the federal government would withhold Medicare and Medicaid reimbursement for the capital expenses of any health care facility that had not been approved by a designated state or regional planning agency. This provision was finally enacted in 1972 as section 1122 of the Social Security Act.<sup>113</sup> State participation in this program was voluntary.

Experience with the comprehensive health planning agencies demonstrated the obvious: they were subject to provider domination, lacked authority to carry out their regulatory role, and lacked the intellectual tools necessary to carry out even a planning function.<sup>114</sup> In order to make these agencies more effective the Congress passed the National Health Planning and Resources Development Act of 1974.<sup>115</sup> The act required the states to enact CON legislation on pain of losing certain federal grants, broadened the powers and responsibilities of the regional planning agencies, renamed them Health Systems Agencies (HSAs), and provided federal funding for them. Nearly half of the states had enacted CON legislation by 1974, and the rest fell quickly into line.<sup>116</sup>

Cost control was not the only object of all this activity, but it was clearly a principal motivation. The problem was that CON did not control costs, a fact that was belatedly called to general public attention in the mid-1970s when economists began to do regression analyses on health care costs in states with and states without CON

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113. Social Security Amendments of 1972, Pub. L. No. 92-603, § 221, 86 Stat. 1329 (codified at 42 U.S.C. § 1320a-1 (1976)).

114. For some representative expressions of discouragement with comprehensive planning agencies, see Havighurst, *Regulation of Health Facilities and Services by "Certificate-of-Need"*, 59 VA. L. REV. 1143 (1973); Luft & Frisvold, *Decisionmaking in Regional Health Planning Agencies*, 4 J. HEALTH POL., POLY. & L. 250 (1979); West & Stevens, *Comparative Analysis of Community Health Planning: Transition from CHPs to HSAs*, 1 J. HEALTH POL., POLY. & L. 173 (1976).

115. National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k-300t (1976), Pub. L. No. 93-641, 88 Stat. 2225 (1974).

116. CON legislation is currently in effect in forty-nine states. Letter from Ronald R. Bryant to Rhoda Powsner (Mar. 23, 1981) (on file with the *Michigan Law Review*).

regulation. In some states early CON had no effect on the pattern of rising health costs. In others, particularly where the jurisdiction of CON regulation was limited to facilities construction and did not include services, CON seemed actually to exacerbate the trend toward rising costs and concentration in the hospital industry.<sup>117</sup> Other economists discovered that the hospital industry seemed to be more concentrated in localities in which regional planning was taking place,<sup>118</sup> and that CON was adopted most quickly by those states in which hospital industry concentration was the highest.<sup>119</sup> None of this should have come as any great surprise: the cost implications of centralizing health care around the large, full-service general hospital had been clear from the beginning.

We express no ultimate judgment on these developments. They are the result of an era when large institutions were thought to be superior to small ones, when technological sophistication was thought to be the measure of quality in medical care, when the nation thought of itself as a land of unlimited resources. The present hospital system is a creation and reflection of the postwar culture that created it. Many of the values and institutions of that culture are now undergoing reexamination in the light of changing economic circumstances and the consequences of the public policies developed during those years. The current controversy over the role of competition in health care and the desirability of devoting major public resources to the treatment of disease as distinct from the promotion of health are reflections of a changing public policy environment. The purpose of this Article has been to offer a clear account of the ideas, policies and institutions that created the present hospital system.

#### APPENDIX I: A NOTE ON VOLUNTARY SECTOR REGULATION

The development of hospital regulation through certificate-of-need closely resembles a phenomenon familiar to observers of regulation: industries frequently seek government regulation to prevent entry by potential competitors, to raise standards, and to place a floor under prices. Hospital planning agencies can be analogized to other regulatory agencies—for example, public service commissions

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117. See E. ROTHENBERG, *supra* note 110, at 106; D. SALKEVER & T. BICE, HOSPITAL CERTIFICATE-OF-NEED CONTROLS (1979); Sloan & Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 23 J. L. & ECON. 81, 101-03 (1980).

118. See J. MAY, *supra* note 44.

119. See W. WENDLING, J. WERNER & N. BUDDE, ECONOMIC REGULATION OF HOSPITALS: AN EMPIRICAL TEST (1978).

and professional licensing boards—that characteristically develop close relationships with the industries and occupations that they regulate. The metaphor of “capture” has often been used to describe the process by which government regulatory agencies come to share the interests and viewpoints of the regulated industries. Where the regulatory scheme embodies the government’s conviction that the public interest and the private interest of the industry are complementary, however, and where the regulatory agency is explicitly charged with promoting the industry’s interests, it is more realistic to think of the agency’s relationship to the industry as familial. The more closely the agency is expected to become associated with the regulated group, the more realistic it is to view the agency as part of the industry itself, and to regard the regulatory scheme as a delegation to the industry of a self-regulation function. The more the regulatory scheme amounts to a delegation of public authority to private parties, however, the more the private self-government itself must be anchored in fundamental democratic values if it is to achieve durable legitimacy.

Health planning agencies lay claim to several varieties of democratic legitimacy, which helps to explain why governments at all levels were apparently so comfortable in creating them and in delegating licensing functions to them. Most health planning agencies are not government agencies, but rather private non-profit corporations. But while these agencies are not government bodies, they can claim to be public bodies in the larger sense.

The voluntary association is a central feature of American political and community life. DeTocqueville applauded Americans for organizing themselves into private voluntary associations in order to perform for themselves functions that otherwise might be performed by government. Pluralist political theory regards voluntary organizations as essential to democratic government. Hospitals are particularly striking instances of private voluntary activity that serves the general interest: until the advent of health insurance, the hospitals were charitable institutions performing the public function of caring for the poor. In the postwar period, voluntary hospitals, through their financing arm, the Blue Cross, have satisfied a public need for health insurance.

The voluntary sector generally resists government control, invoking the principle of limited government and challenging the idea that government action, particularly federal government action, is always to be equated with action in the public interest. Their alternative system of self-regulation through comprehensive community-based

planning agencies appeals to the mystique of face-to-face democracy among leaders who genuinely represent the community. With its broad base of active political support in the civic-minded community leaders who serve on hospital government boards, the voluntary hospital establishment has awesome political power. Its command of community support and political legitimacy has contributed to the governments' reluctance to regulate hospital costs directly or vigorously.

The idea of voluntariness encompasses the related idea that non-coerced action is preferable, on both moral and political grounds, to action that is compelled by threat. "Voluntary" action, even if it is taken in order to avoid potentially unpleasant consequences of inaction, preserves the semblance of moral choice and autonomy on the part of the actor. "Voluntary" self-regulation undertaken by an industry in response to the threat of government regulation allows the government to capture private initiative and ingenuity in the pursuit of government objectives and thus to conserve government resources, albeit frequently at the price of modifying the government's original objectives. The government has not only accepted but encouraged hospital self-regulation as an alternative to direct government interference.

In the case of hospital CON regulation, another element is at work as well: the government has an interest not only in curbing hospital construction but also in enhancing the quality of care. Government is much better at enforcing minimum standards than in promoting excellence; it thus has tended to lend its authority to private voluntary organizations that have a positive commitment to collective self-improvement in functional areas—for example, education and health—in which government has an interest.<sup>1</sup> Hospital regulation through mandatory regional planning and certificate-of-need should be viewed as an instance of cooperation between the government of the public sector and the government of the voluntary sector. The voluntary government has political legitimacy, a powerful and loyal constituency, access to influential centers of elite opinion and control over some of the most important institutions in national life. It plans, governs, and regulates.

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1. See Finken, *Reforming the Federal Relationship to Educational Accreditation*, 57 N.C. L. REV. 379 (1979). The voluntary accreditory agencies, like systems of professional self-governance (e.g., bar associations and medical societies), derive their legitimacy from the idea that the profession as a whole has an interest in maintaining high standards. Although the anti-competitive aspects of some professional rules have recently come under attack, there is not likely to be serious movement toward replacing professional self-government altogether with government regulation.

Hospital planning agencies are cousins to local community health and welfare councils, which are the private governments of the charitable sector in most cities. Collective action in the charitable sector seems to have originated with the idea of "scientific" use of the charitable dollar, an idea borrowed from the English by American urban reformers in the 1870s. By 1895 there were nearly 100 Charitable Organization Societies in American cities. These organizations, supported by private foundations, leaders of commerce and industry and the philanthropic public, served as intermediaries between individual needy people and the various assistance programs. By the end of the nineteenth century, the local COS was the acknowledged centerpiece of most cities' private charitable enterprises. In addition to investigating the relief needs of the poor, the COS would typically evaluate the relief-giving efforts of the charitable agency itself. Reports evaluating the effectiveness of the most visible charitable agencies were circulated to potential donors and to public authorities in an attempt to improve what the COS perceived as inefficient practices. The practical effect of this activity was that the local COS functioned as a quasi-regulatory visiting committee for the charities.

Another common example of voluntary sector planning and self-regulation is represented by the united fundraising campaign. The first Community Chest was formed in Cleveland in 1913; combined fundraising drives became nationally significant during World War I when, operating as War Chests, they combined wartime patriotic appeals with community welfare drives. By the end of the war more than 400 such organizations had been established. Joint fundraising necessarily entails some planning and regulatory function; the fundraising agency becomes a kind of guarantor to the public that the programs on whose behalf the appeal is made are necessary for the public good, and that the agencies themselves are respectable and professionally managed.

Hospitals are not usually included in general community fundraising drives because their large capital requirements dwarf the requirements of other voluntary social service agencies and because they do not depend for their operating revenues upon community-wide charitable solicitations. Hospital councils that have community representation may have close ties to the larger voluntary sector. The Greater Detroit Area Hospital Council, for example, derived two-thirds of its support from the United Foundation of Metropoli-



tan Detroit.<sup>2</sup>

The influential New York City voluntary hospital planning organizations are the progeny of the Hospital Saturday and Sunday Association of New York City, which was formed in 1880 as a united hospital fundraising drive. The Association functioned also as a trade association; for example, it promoted sound accounting and management practices and negotiated reimbursement rates with the City for charity patients on behalf of all the hospitals. It evolved into the United Hospital Fund, which continued to perform the combined functions of fundraiser and trade association and served as the hospitals' emissary to other federations of charitable organizations.<sup>3</sup>

During the financial crisis of the 1930s the United Hospital Fund was the vehicle through which the hospital community of New York adopted the two principles of voluntary prepayment and voluntary community planning. In 1935 the United Hospital Fund invited one hundred prominent citizens of the metropolitan area to sponsor the Hospital Survey for New York.<sup>4</sup> The principal fact that the Survey had to deal with was that patients could not afford hospitalization. Several recommendations of the Survey were aimed at managing existing hospital capacity and constraining future growth since it had determined that many of the problems of the hospitals resulted from "lack of orderly development and of broad planning on a community basis."<sup>5</sup>

The Survey identified the problem as over-capacity, and recommended conservative planning on a regional basis. Most intriguingly, it recommended that no new hospital construction be allowed to proceed without the approval of a community-based body with quasi-regulatory power:

The truly colossal investment of the community in the erection and operation of hospitals and the complexity and essential interrelation among these, and between the hospitals and other institutions and agencies for the care of the sick, make necessary the development of some group, trusted alike by the contributing public and the city government and by the voluntary hospitals whose judgment and opinion would be so respected that no new hospital nor extension of existing ones would be undertaken without its approval. Only . . . [thus] can the community be saved from extravagance and waste in hospital building and maintenance.<sup>6</sup>

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2. See 2 W. McNERNEY, HOSPITAL AND MEDICAL ECONOMICS 1252 (1962).

3. See J. HIRSH, SATURDAY, SUNDAY AND EVERYDAY 11-13, 19-27 (1954).

4. *Id.* at 56.

5. *Id.* at 57.

6. *Id.* at 58.

In response to this recommendation, the United Hospital Fund sponsored formation of the Hospital Council of Greater New York, which had as members seventeen community agencies and the City of New York. It began its work in 1938. Its purpose was

to coordinate and improve the hospital and related services of New York City and to plan the economical development of these services in relation to community needs. It is a cooperative endeavor representing both community and governmental interests. Its effectiveness in the community will depend not on legal authority but on the competence of the organizations and individuals which compose it and on the confidence in its judgments accorded by the public and the institutions affected.<sup>7</sup>

Community planning for hospitals, therefore, was voluntary, requiring the leverage of public opinion and the cooperation of private givers to be successful. In several other cities, private corporate and philanthropic sources of capital took an interest in assuring themselves that the funds that they donated for hospital construction were to be used in accordance with real need. Beginning in the early 1940s, following the lead of New York City, hospital or health planning agencies were launched in Columbus, Rochester, Detroit, Chicago, and Pittsburgh, among other cities. These planning agencies were at first dominated by corporate interests who concentrated on minimizing the level of charitable solicitation directed toward themselves by constraining and spacing the amount of new hospital construction.<sup>8</sup> With the spread of Blue Cross plans, however, which paid capital as well as operating costs, the hospitals no longer depended primarily on industry to raise funds for building, with the consequence that corporate representation deteriorated to a consumer interest. Gradually health care professionals became more influential in the affairs of the planning agencies; relationships were established with Blue Cross, insurance companies, banks, and a variety of public and private agencies. The Hospital Council of Greater New York was accustomed to reviewing proposals for construction or expansion submitted by the voluntary hospitals in the New York metropolitan area.

When the leaders of the public health and hospital establishments recommended regional health planning as a solution to the disorders of the hospital world in the late 1950s, they were proposing

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7. *Id.* at 61.

8. See Gottlieb, *Brief History of Health Planning in the United States*, in *REGULATING HEALTH FACILITIES CONSTRUCTION* 7-15 (C. Havighurst ed. 1974).

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to multiply institutions that were already familiar to the leaders of the hospital industry. If community planning with "teeth" in accordance with the traditions of the voluntary sector could deflect concern over rising hospital costs and restore the public's faith in the hospitals, there would be no need for more drastic intervention by the government, an intervention, that it is probably fair to conjecture, no one, including government officials themselves, wished to force on an unwilling hospital sector unless all else had failed.

The hospitals' desire to continue the tradition of self-governance through regional planning agencies coincided with increasing interest in community participation and local self-determination in public policymaking in the 1960s. Comprehensive health planning agencies were viewed as opportunities for consumers, particularly members of medically under-served communities and other interested parties, to participate for the first time in what had hitherto been the closed arena of hospital decision-making. Unfortunately, these agencies were destined to become instrumentalities of hospital rather than community control.

#### APPENDIX II: ROEMER'S LAW AND EFFICIENT HOSPITAL SIZE

One of the intriguing questions arising out of the passage of certificate-of-need legislation is why so many people could have been misled into believing that CON would constrain hospital costs. Part of the answer lies in the Hill-Burton Act, which committed the hospital planning profession to measuring the number of beds as a least common denominator of hospital capacity. We believe that the question of controlling the number of beds became confused with the question of controlling total hospital costs partly because of the advent of "Roemer's Law."

#### I.

In 1959 Milton Roemer and Max Shain of the Cornell School of Hospital Administration theorized that under conditions of widespread insurance coverage, the supply of hospital beds in a community or state is the major determinant of the hospital utilization rate.<sup>1</sup> The observation was immediately dubbed "Roemer's Law"; virtually overnight it became a fundamental axiom of hospital economics. Roemer argued that new hospital beds built in a community will not

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1. See M. ROEMER & M. SHAIN, HOSPITAL UTILIZATION UNDER INSURANCE (1959); Roemer & Shain, *Hospital Costs Relate to the Supply of Beds*, 92 MOD. HOSPITAL, Apr. 1959, at 71. A later paper is Roemer, *Bed Supply and Hospital Utilization: A Natural Experiment*, HOSPITALS, Nov. 1, 1961, at 36.

drain patients from existing facilities or even result in a lower average rate of occupancy across all hospitals; rather, the new beds will simply fill up to the same degree to which the old beds filled up. He observed "very little variation in hospital occupancy percentages, regardless of the supply of general beds available per 1000 persons. In other words, hospitals in undersupplied areas are not appreciably more crowded with patients than hospitals in areas of high bed supply."<sup>2</sup> Roemer's observation was quickly reduced to the axiom that "if a hospital bed is built it will be used." It seemed to explain the enigmatic but observable fact that older hospitals did not suffer declines in occupancy rates when new hospitals were built.

The implication for public policy was clear:

if there is to be any effective control over the utilization rate, it should rest first of all on some sort of control over the supply of beds that are built and put into use . . . . Whatever the level should be, it would permit the community, state, or nation to finance hospital service at a level which it is prepared to finance — without anxieties and diatribes about overuse, mismanagement and waste.<sup>3</sup>

Roemer's theory assumed the continuance of the very economic forces that were driving the hospital cost spiral. His "law" was an observation about the effect of widespread health insurance on hospital utilization. He did not suggest reforming the basic structure of financial incentives. Most importantly, Roemer's Law was a theory about hospital utilization, not hospital cost. Utilization and cost are related but they are not the same: sparse and prudent use of a very expensive facility might generate as much cost as unjustified overutilization of a very inexpensive one. Moreover, the issue of whether costs or utilization should be controlled was distinct from the question of what level of resources the society should devote to hospital care. Hospital costs might well rise even more steeply after a region's bed supply is controlled if the government authorizes an increase in either the number of beds per capita or the intensity of care. The critical missing element that Roemer and Shain wished to supply was explicit public decisionmaking.

Public decisionmaking, which Roemer and Shain equated with government decisionmaking, would deflect unjustified criticism of the hospitals. If the government would determine authoritatively how many hospital beds the population actually needed, it would legitimate higher costs associated with the utilization of that number of beds and would eliminate the public perception that high costs

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2. M. ROEMER & M. SHAIN, *supra* Appendix II note 1, at 13.

3. Roemer, *supra* Appendix II note 1, at 41.

were the result of extravagance and waste caused by "overutilization." Once having controlled the bed supply, the government could then determine what percentage of hospital costs it wished to subsidize under compulsory health insurance, which Roemer advocated.

Roemer supported CON, however, because he believed it would reassure the public that higher hospital costs, which he believed were both inevitable and justified, were necessary for the health of the community:

The operation of a higher degree of public surveillance of public hospitals could be reassuring to the public that hospitals are indeed being operated judiciously. Hospitals could show that their operations are within established standards that do not emanate from the brain of a single administrator or a single board, but that they come from the judgment of a state-wide authority. They could also enforce higher standards where necessary, since in the last analysis I think that lives are more important than dollars, even if the saving of lives means higher expenditures. From personal experience in the administration of a hospital program, I can tell you that an extensive program of public supervision of hospitals as it has been carried out in Canada and elsewhere has not resulted in any reduction in hospital services, personnel or equipment, but has generally led to an expansion of services with improvements in quantity and quality.<sup>4</sup>

Roemer's Law reinforced the idea of the hospital bed as the fundamental unit of hospital capacity. It stressed the urgency of asserting public control over the number of beds in order to constrain the costs of hospital care. His proposal to control the number of beds, however, was part of a program for total government control of hospitals by a combination of capacity restraints and financial subsidies. There was some resemblance between Roemer's desire to place a legitimate lid on total expenditures and the Blue Cross's desire to limit its liability: both wished the public to understand and to acquiesce in the rising cost of health care. But Roemer wanted to create conditions under which the government would determine the size of the health care budget, while the Blue Cross and the hospitals wanted to maintain their public service legitimacy precisely so that the public would *not* turn to the government for such decisions.

There was also a critical difference in their concept of *control*. Neither the Blue Cross nor Roemer and Shain thought that hospital capacity limitations could be expected to *reduce* or *stabilize* hospital costs. Roemer and Shain advocated control by way of authoritative decisions made by publicly accountable government officials through processes that would weigh expenditures for health care

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4. 1962 JT. COMM. REPORT, *supra* note 93, at 95.

against expenditures for defense, roads and welfare. Roemer and Shain's preferred scenario was the hospitals' nightmare. What the Blue Cross and the hospitals had in mind when they used the term *control* was self-regulation through voluntary hospital planning councils. Government regulatory authority was to be exercised, if at all, only in support of decisions made by nearly autonomous regional planning bodies dominated by elite providers of medical and social service. Funding was to continue to be provided by the Blue Cross and other private insurers, whose total budget would be constrained only by the public's ability and willingness to pay the full cost of care as reflected in health insurance premiums. Although Roemer and Shain on the one hand, and the Blue Cross and the voluntary hospitals on the other agreed on little else, they shared the view that some government-enforced limitation on hospital beds would legitimize the growth of the hospitals and deflect concern over rising costs. Roemer's Law became a plausible rationale for certificate-of-need controls even to persons who did not share the institutional philosophies of the voluntary hospital establishment.

Some economists and lawyers who have looked back at the development of certificate-of-need legislation have asserted or assumed that its theoretical underpinning was Roemer's Law.<sup>5</sup> We believe that the existence of Roemer's Law has diverted attention from the actual economic and political imperatives that led to and presently sustain certificate-of-need regulation. To attribute CON legislation to Roemer's Law is to mistake a convenient theoretical justification for an actual motivation.

## II.

The difficulty with using beds as a measure of hospital capacity and community need is that the gross number of beds is not a surrogate for the quantity, quality, or type of services delivered. This problem was not apparent when the concept of planning the ratio of beds to population was first developed in the 1920s because hospital services were not differentiated to any significant degree. Even by the late 1950s the case mix as indicated by diagnostic category in various institutions did not vary markedly. The referral hospitals were using more advanced surgical and diagnostic techniques but the true tertiary care institution had not yet come into being. As hospital services became more differentiated in the 1960s, the hospi-

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5. See, e.g., Bicknell & Walsh, *Certification-of-Need: the Massachusetts Experience*, 292 NEW ENGLAND J. MED., May 19, 1975, at 1054; Havighurst, *supra* note 114, at 1158-59; Sloan & Steinwald, *supra* note 117, at 83.

tal became a multiproduct institution whose capacity or output could not usefully be measured simply by its number of beds. Nonetheless, hospital planners have continued to use the bed as the standard measure of hospital capacity and continue to search for an optimum ratio of beds to population. The inherent limitations of this approach can perhaps be illustrated by a homely analogy.

Imagine a society in which all vehicles are custom-built in workshops owned by supply houses that furnish parts and equipment. Individual builders rent stalls in the workshops and may produce bicycles, motorcycles, trucks, trailers, sports cars, mobile homes, recreational vehicles, hearses, fire engines, sedans or tractors. If the government were to begin planning industrial capacity to meet transportation needs and therefore needed to decide how many workshops to allow to function with what number of stalls, it would surely not use crude demography to measure something called "society's need for vehicles"; rather, it would ascertain the demand and need for the various classes of vehicles and would allocate workshop space, supplies and equipment in proportion to the types of vehicles it had decided to allow to be built.

Hospital planning on the basis of bed capacity is the equivalent of transportation planning on the basis of gross stall capacity: it does not attempt to measure the actual need for the separate products of the multiproduct firm. This omission reflects the historic division of labor between those who supply capital and those who decide how facilities will be used once they are built. Hospital planning began in the 1920s as a service to the voluntary hospitals themselves and to the corporate and philanthropic interests that were the sources of funds for capital expenditures. During the 1920s and 1930s, when the services rendered in hospitals were much less sophisticated and differentiated than they are now, it was reasonable to speak of beds as the least common denominator of hospital services. Measuring hospital capacity by number of beds provided a shorthand vocabulary, accessible to hospital administrators, planners, and businesspeople accustomed to dealing in costs per square foot and other standard measures. The philanthropic and corporate interests involved in the planning process did not purport to determine the type of services to be rendered within the hospital; admitting physicians determined whether hospitalization was necessary and decided what services a patient required while in the hospital.

When the United States Public Health Service became interested in hospital planning during World War II, it assumed that the main task was to ensure that scientifically trained physicians would prac-

tice in geographically dispersed hospital facilities to which the whole population might have access; the government did not purport to determine what specific uses should be made of the facilities, leaving those decisions, in accordance with custom, to the physicians and hospital administrators. The objectives of the federal government were thus consonant with the objectives of the voluntary hospital establishment. The federal government therefore adopted the assumptions and methodologies of the voluntary sector and in the process of doing so legitimated them as public policy. The planning guidelines of the Hill-Burton Act, although crude, were reasonably adapted to their purpose, which was simply to ensure a wide distribution of hospital facilities.

The limitations of measuring hospital capacity by the number of beds became apparent when in the 1960s it was proposed to ration hospital services by curtailing the supply of hospital beds through certificate-of-need laws. True rationing of capacity in accordance with the public interest would require that someone identify the separate products of the multiproduct hospital firm, determine the public need and demand for each service, determine the most economical means of providing each service, and so on. This task is simply beyond the capabilities of the hospital planners, for reasons that are partly intellectual, partly institutional, and partly political. There are no adequate measures of the efficacy of many medical procedures (*e.g.*, heart by-pass surgery) and there is therefore no defensible method of determining how many such procedures are "necessary"; such decisions are customarily entrusted to the clinical judgments of physicians. Moreover, changing tastes in medical practice mean that the service to be measured is in a state of constant flux. Rationing in this context is necessarily arbitrary; like other forms of planning that are not shaped by intellectually coherent standards, it has tended to deteriorate into political bargaining among hospitals, bargaining that has become the hallmark of certificate-of-need regulation.

### III.

The evolving preeminence of large hospitals has shaped patterns of health care delivery in ways that have not been fully appreciated. Large hospitals have dominated the health planning process, with the consequence that large hospital practice has become standard medical practice. Regional planning increasingly permits hospital administrators and health planners to control the delivery of medical care. Most of the institutional economies claimed for the large hos-



pitals are derived from their having a large enough patient population to justify expensive facilities, equipment, and ancillary services. Once the hospital has invested in such items, its administration has an interest in encouraging their utilization. In addition, some of the ancillary services (*e.g.*, radiology, pathology, and pharmacy) have been viewed as profit centers. The pressure in the large hospital is therefore toward intensive utilization and perhaps overutilization of facilities once they are in place, a dynamic made possible by the relative indifference of physicians, patients, and health insurers to cost-benefit considerations.<sup>6</sup>

The hospital has always been considered a doctors' workshop, a model that is clearly appropriate for a small hospital. As a hospital becomes larger, however, hospital administrators become more influential. There is probably considerable variation among institutions, even of similar size, in the degree to which hospital administrators can effectively control the practice of medicine within the institution. What is not so commonly understood is the heterogeneity of relationships between staff physicians and the hospital administration within a single hospital. Hospital administrators, whose professional prestige is enhanced by the size, complexity, and sophistication of their institutions, have a natural community of interest with staff physicians whose modes of practice utilize sophisticated technologies and justify further institutional expansion. The community of interest may be reflected in hospital administrators' allocation of resources among staff physicians,<sup>7</sup> in administrative decisions to contract out the management of particular hospital departments to closed groups of physicians,<sup>8</sup> and in decisions to close the medical staff or to discourage the granting of staff privileges to physicians whose modes of practice do not further the hospital's aspirations.

As the hospital industry has organized itself into fewer but larger units, the large hospitals and their medical staffs have gained relatively greater power to decide which physicians may hospitalize patients; they therefore effectively control the private practice of medicine, since physicians need hospital privileges in order to serve their patients fully. The leaders of the hospital establishment have identified this effect as a virtue, arguing that the large hospital's selectivity protects the public against physicians who may wish to per-

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6. See Feldstein, *The High Cost of Hospitals — and What To Do About It*, PUB. INTEREST, Summer 1977, at 40.

7. See Holoweiko, *Why Hospitals May Be Giving Your Colleagues an Edge*, MED. ECON., Jan. 21, 1980, at 85.

8. See M. THOMPSON, ANTITRUST AND THE HEALTH CARE PROVIDER 149-71 (1979).

form procedures for which they are not qualified. The granting or withholding of hospital staff privileges thus serves as yet another level of medical licensing and certification. On the other hand, the physicians on the existing staff of a hospital are typically in private practice themselves; in determining which physicians to admit to the staff they are also determining which physicians will compete with them.

An additional effect of capital investment in large hospital facilities is rigidifying of medical practice around current patterns of treatment favored by the institution. The practice of medicine at the larger hospitals has set community expectations and medical standards; the malpractice crisis has developed as the legal negligence standards have followed and reinforced the evolving predominance of large hospital practice which, as we suggest above, has been heavily influenced by the hospitals' own preferences for capital- and service-intensive modes of treatment.

The hospital and public health establishments justify their commitment to the large hospital, as we have seen, by the number of services that the large hospitals can provide, the quality of care that is thought to be associated with large size, and the control over the practice of medicine that institutional centralization makes possible. Economic efficiency *per se* is rarely advanced as a justification for the largest hospitals, although it is used as an argument against the small hospitals that cannot support a full range of services. Contemporary hospital economists generally agree that the optimum size for a general short-term hospital is in the range of 200-300 beds.<sup>9</sup> But what is a short-term general hospital, and what is it supposed to produce? A hospital does not produce a product; a hospital provides a setting in which medical services are dispensed. The most efficient plant size for a hospital is the size at which medical services can be dispensed most efficiently.

If maximum efficiency were the goal, then every hospital would be sized to accommodate the functions that must be performed under the same roof, and those ancillary services that have a coincident efficiency peak; other services would be provided by outside firms on a contract basis. The functions that must be provided to nearly all patients and that must be housed together for the sake of adequate patient care are medical beds, surgical beds, an operating room, a laboratory that can supply blood and other essentials, food

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9. See, e.g., P. FELDSTEIN, HEALTH CARE ECONOMICS 177-86 (1979).

service, and a nursing staff. There should be an optimum plant size for these functions.

Once the size of the basic unit is established, it should then be possible to decide which ancillary services to provide through in-house employees and which to provide through external suppliers. For example, assume that a single physical therapist can provide service to twenty-five patients per day. If a hospital has twenty-five patients per day for whom the marginal benefit of physical therapy is equal to  $1/25$  of the cost of employing a physical therapist, it makes sense for the hospital to employ a full-time therapist. If it has only ten such patients and the hospital hires a therapist, one of two things will happen: either the therapist will render service only to those ten, in which case they will receive service of which the fully allocated cost is more than twice the marginal benefit; or the hospital will treat the therapist as a fixed cost and will find fifteen more patients for whom the marginal benefit of the service is less than  $1/25$  of the cost of the therapist — in which case the fully allocated cost is less but there is still economic waste of some portion of the therapist's efforts.<sup>10</sup> Although this example may seem trivial, the distinguishing characteristic of the large hospital is its labor-intensiveness and the multiplicity of its ancillary services. Economies of scale in the hospital have ordinarily been evaluated in terms of capital-intensive functions (for example, surgical intensive care units); however, inefficient use of labor can be equally wasteful.

A concern for efficiency in sizing hospitals might bring about a

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10. If the health care industry desired economic efficiency, it would make sense for a group of physical therapists to create an independent firm that could provide as much, and only as much, service as a hospital's patient mix actually required. This is the normal industrial model: an automobile manufacturer does not attempt to make all of the components that comprise an automobile, but rather may purchase engines, transmissions, ball bearings, and other parts from other firms properly sized to their tasks. That is not the pattern of the hospital industry; every hospital typically attempts to provide both its basic and its ancillary services in a single plant, with rare exceptions for industrial functions such as laundry, cleaning, and equipment supply.

This commitment to the full-service, integrated hospital would not be possible, however, in the absence of widespread full-cost reimbursement by insurers that are relatively indifferent to cost considerations. Hospital administrators, who derive prestige from the size of their staffs and the number of ancillary services that their institutions provide, can afford to satisfy their own inclination to have total control over all elements of the hospital's functioning by having all services provided in-house. Administrator preferences are reflected in the Joint Commission on Accreditation of Hospitals standards, which further reinforce administrators' inclinations to have all services performed by their own employees.

These economic and institutional factors are reinforced by medical culture. All ancillary services are support for the physicians, most of whom are male; most of the ancillary paramedical services are specializations of nursing, which is a predominantly female profession. Splitting off functions from large, sheltering institutions and lodging them in smaller private businesses would require a willingness to undergo economic risk that is not common in the socialization of women.

closer relationship between the nature of the institution and the actual needs of the patients that it serves. It is well-known that the vast majority of the patients who require hospitalization could be treated adequately in relatively uncomplicated primary or secondary care facilities. The idea that the efficient general hospital is one with 200-300 beds is predicated on the definition of a hospital as an integrated, full-service institution with internal subsidies, some teaching function and an appropriate degree of specialty medicine. This self-definition on the part of the hospital industry is reflected in the standards of the Joint Commission on Accreditation of Hospitals. If the hospital industry were redesigned primarily with economic efficiency in mind, smaller noncentralized hospitals might be appropriate for most purposes; complex facilities might be centralized and sized properly for the number of patients who require them. Achievement of greater economic rationality in the hospital industry will require, however, a substantial redesign of the insurance function to eliminate existing incentives for inefficient hospital size.