THE HOSPITAL-BLUE CROSS PLAN RELATIONSHIP

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An Introductory Note . . .

The working relationship between Blue Cross Plans and hospitals represents a uniquely American interaction between health service money and programs. As such, it has significant potential for the realization of new concepts of cost effectiveness, continuity of care, and access.

In a period of increasing demands for change, it is important periodically to take inventory of such basic relationships. With respect to Blue Cross Plans and hospitals, the evolution through the Fifties was examined in 1961, resulting in new and significant realignments. Again, in 1971, the relationship was evaluated and additional changes were made at the national level.

Reflecting the increasing pace of change, Blue Cross Plans sought a new diagnosis this year, after a span of only five years. This time, the role of the hospital - Blue Cross Plan relationship in serving the broad public interest was examined by Robert Sigmond, with Thomas Kinser, in their capacity as independent consultants.

Their provocative report follows. No formal action has been taken on the report, but the Blue Cross organization will use it to stimulate a series of reappraisals—local, state, and national—leading to a sharper focus on the role of community-based linkage between financing and hospitals, a complex and potentially innovative public bond.

Walter J. McNerney

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Foreword

The authors believe that the future vitality and effectiveness of hospitals, the Blue Cross organization and, in fact, the entire range of health care service activities in the United States will be greatly influenced by the relationship between hospitals and Blue Cross Plans during the decade ahead. In particular, the balance between governmental and non-governmental decision-making in health services will largely reflect the extent to which hospital-Blue Cross Plan relationships serve the community interest. Constructive interaction by Blue Cross Plans and individual hospitals in response to public pressure for cost containment, reform and increased effectiveness of medical care will be crucial.

The basic facts are that Blue Cross Plans have contracts with almost all hospitals; that over 90 percent of the nation's hospitals selected Blue Cross Plans as the Medicare intermediary; that over 20 billion dollars flows annually between Blue Cross Plans and hospitals (well over half the total income of community hospitals); and finally, that these relationships are all subject to governmental regulation, inspection, public hearings and approval. This report does not question whether there should be a hospital-Blue Cross Plan relationship. Rather it concentrates on how to increase its value in order that both can operate more efficiently and more effectively, thereby providing quality services to their patients, subscribers and communities at a lower cost than might otherwise obtain.

Some readers will be disappointed that this report does not attempt to provide answers to some of the difficult substantive questions at issue between Blue Cross Plans and hospitals, such as:

- -What are the best tools available to Blue Cross Plans in helping hospitals to control costs?
- -Has the Blue Cross organization done enough in providing ambulatory care and other alternative benefits?
- -Is differential payment justified?
- -How should Blue Cross Plans pay hospitals?
- -Should Blue Cross Plans move strongly to deductibles and co-insurance to control costs and utilization?
- -What should be the Blue Cross organization role under National Health Insurance?

These issues are of crucial importance and, while we do have views, for the most part we do not discuss them in this report. Our study concentrates on defining the framework and processes of Blue Cross Plan-hospital interactions in which substantive issues can be addressed most constructively.

The goals of the study were to:

1. Analyze the current status of hospital-Blue Cross Plan relationships locally and nationally.
2. Identify the external forces at work in the next decade and project how they will influence the content and nature of the relationship.
3. Suggest specific steps that the Blue Cross Association and individual Plans should take to improve the effectiveness of their relationships with hospitals in serving the public.

We knew from the beginning that no simple universal prescriptions are available to strengthen hospital-Blue Cross Plan relationships throughout the country. Hospitals and Blue Cross Plans and their relationships vary widely across the nation in many important respects, especially as they relate to physicians, Blue Shield and government. Throughout our work, we became ever more aware of this wide diversity, and of the strengths as well as the weaknesses associated with it. We attempt to identify common themes and mechanisms that can be adapted to fit a variety of local situations.

The entire study had to be completed in a few months because of other commitments of the authors. All of the work (involving visits to ten Blue Cross Plan areas, review of detailed information requested from all Plans, many sessions at the Blue Cross Association and the American Hospital Association and review of their files, and many interviews with knowledgeable people in government, academia and public life) took place during the first six months of 1976.

In focusing sharply on Blue Cross Plan-hospital relationships, we necessarily neglected other important relationships that should be examined in detail to give a complete picture of the potential value of the interaction of Blue Cross Plans and hospitals. Of special importance is the potential for joint action by Blue Cross and Blue Shield Plans in working with hospitals and physicians in a variety of medical staff and other professional settings. We also would have liked to examine in more detail the interaction of such programs as Medicare with the Blue Cross Plan-hospital relationship.

The report is not a piece of research, or even an example of disciplined gathering and organizing of systematic information. Rather, it takes the form of a consultant's report, providing impressions, insights and judgment. We hope that this report will stimulate a wide variety of more scientific studies.

We gratefully acknowledge the help of those in all of the Plans who responded so fully and frankly to our questionnaires; of everyone in the Blue Cross Plan areas we visited, including the executives of member hospitals and hospital associations; of the staffs of the Blue Cross Association and the American Hospital Association who gave so generously of their knowledge and insight; and of all the others who helped us to gain perspective on an important subject. We were fortunate to have the wise counsel of C. Rufus Rorem. Special recognition goes to the president of the Blue Cross Association for supporting this project. At the same time, the authors alone are responsible for the final product.

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I. The Hospital-Blue Cross Plan Relationship: The Options

A special relationship with hospitals is one of the important characteristics of a Blue Cross Plan. From the beginning, a contract between the parties reflected a common commitment to more accessible community hospital service at monthly premiums that the public could afford. Nationally and in many Plan areas, a variety of forces is currently exerting strong pressures on this relationship. Rising hospital costs, increased federal and state governmental responsibilities for financing and regulation of hospital care and concern about the impact of "third party" payments on managerial efficiency or quality of care have all led to questioning—within the Blue Cross organization, among hospitals and by the public—the effectiveness of the relationship.

Some hospital spokesmen see the relationship in terms of imposition of rigid and unfair fiscal limitations which threaten standards of patient service and managerial flexibility. Some public spokesmen see the relationship in terms of a "coziness" that interferes with a disciplined buyer-seller interaction. The capacity of the relationship to serve the broad public interest is not as clearly articulated or understood as in the past.

Any Blue Cross Plan-hospital relationship can be viewed as having two basic dimensions reflecting the extent to which the parties are (1) *getting along* and (2) *getting something accomplished* in the public interest. The fundamental concern of this report is with the second dimension. Benefits of an improved relationship between hospitals and Blue Cross Plans should accrue to patients, to subscribers and to the communities served.

Currently, these two dimensions are not necessarily related in any simple way; all possible configurations are found among the 69 Plans, and within each Plan in its relationships with individual hospitals.

Although little of value is usually accomplished among parties which do not get along, there are important exceptions in some Plan areas. By the same token, in some areas where parties do get along well, clear-cut benefits to patients and subscribers are not easily identified. Assessment of the capacity of a Blue Cross Plan-hospital relationship to respond responsibly to a wide variety of community, public, professional and institutional demands involves careful ex-

amination of both dimensions of the relationship. Accordingly, the concern of this report is with the full range of Blue Cross Plan interactions with individual hospitals, rather than with the hospital contract, reimbursement, the activities of the provider relations staff or any other specific facet.

Throughout, the fundamental search was for answers to this question: How can the Blue Cross Plan-hospital relationship be shaped to contribute to more efficient and effective health care service to the public during a period of strong pressures to contain rising costs and to reform the health care system?

Blue Cross Plan-hospital relationships are extremely complex. The relationship in fact encompasses uncounted millions of interactions related to a majority of all hospital patients. Thousands of Blue Cross Plan and hospital employees at various levels work with each other on money and data flow; budget, rate and utilization review; health planning; and many other functions. The relationship varies widely—as Plans and hospitals and their community settings vary.

In general, an individual Blue Cross Plan's approach to its hospital relationship over the years has been determined by the Plan's primary emphasis on eliminating financial uncertainty associated with hospital service. In an earlier period, when Blue Cross Plans were attracting initial subscribers to a new idea, hospital relationships were secondary to marketing efforts, reflecting a visible community partnership committed to low premiums and easy access to hospital care. Later, as volume increased, as hospital costs rose, as technological gains proliferated and were absorbed, and as commercial competition exerted strong pressure, emphasis shifted to improved efficiency of processing claims and more businesslike hospital relationships.

Currently, with government moving to mandate universal entitlement to health insurance benefits and with strong public pressure for hospital cost containment, some Plans find themselves in adversary relationships with some hospitals. Some Plans are working closely with individual hospitals in joint innovative programs to contain hospital costs. Pressures and priorities are changing and are affecting Blue Cross Plan-hospital relationships.

But few Plans have as yet systematically reassessed the goals and objectives of their hospital relationships to develop a coordinated program in response to new forces and new public requirements.

The current importance of the Blue Cross Plan-hospital relationship lies in its great potential to respond constructively to pressures for change in the health care system. Public spokesmen are insisting on reform to control costs, eliminate or upgrade substandard quality service, broaden access to primary care, harness technology, avoid unnecessary duplication of services and advance health maintenance through alternative delivery systems and health education programs.

Unfortunately, there are still few tested and proven practical techniques to achieve these important objectives anywhere in the world. There are no easy answers available to government, Blue Cross Plans or hospitals. Complex changes in the behavior of professionals, patients and the public are involved. Any change imposed on health care institutions, with strong built-in resistance to disturbance of long-standing professional working relationships, runs the risks of unexpected side effects. At the same time, much can be accomplished by testing and demonstrating the value of new approaches in appropriate hospital settings. Blue Cross Plans have a unique capacity to work with individual hospitals, and should, in conjunction with Blue Shield, help to bring about productive change during this complex period in health service history. The disciplined public service orientation that such Blue Cross Plan-hospital interaction requires can influence the nation in its search for an effective balance of voluntary and government responsibilities in the U.S. health care system which is emerging.

For an individual Blue Cross Plan, organizing hospital relationships to help in improving community health service effectiveness requires a strategy that reflects understanding of the wide variation in hospitals. The typical Plan works with about 50 to 75 hospitals that vary widely not only in size and scope of service programs, communities served and physical facilities, but also in governance capability, managerial and financial resources, involvement of physicians in management and capacity to innovate. Common exploration of the public interest by a Blue Cross Plan and individual hospitals can lead to a variety of working arrangements.

Three Basic Options. In relating to an individual hospital, a Blue Cross Plan appears to have three basic options, depending upon its own capabilities, characteristics of the individual hospital and the community setting and external forces impacting on the hospital and the Plan.

1. A primary focus on *systems efficiency*, so that the Blue Cross Plan can keep its own operating costs down, provide prompt and accurate claims processing services to the participating hospital and the subscribers it serves, and be competitive. Systems efficiency must be a key element of any Blue Cross Plan-hospital relationship, without which little more can be expected. This approach is necessary but not sufficient to meet the challenges that lie ahead.

Improvement in basic processing systems may be all that is currently possible with hospitals which are not yet prepared to face up — with their medical staffs — to the realities of increasing public pressures for reform and to the continuing erosion of institutional self-determination that is the inevitable consequence of insensitivity to the public. With such hospitals, Blue Cross can only focus on increased efficiency of mechanical systems while it seeks some basis for more dynamic interaction in the future.

In other hospital situations, a basic systems efficiency approach may be all that is immediately achievable because the hospital management team — often in a key hospital with demonstrated interest in new directions — lacks confidence in the Plan's capability to interact in terms of health care services innovation. Some Blue Cross Plans lack trained personnel with sufficient understanding of the health care setting to be able to participate effectively in working out extremely sensitive institutional and professional change processes.

Efforts to go beyond a systems relationship in the absence of mutual confidence between the Plan and the hospital is likely to result only in friction, tension and lack of results for any investment involved.

2. A primary focus on an *interdependent relationship*, recognizing that the Blue Cross Plan must represent consumer-subscribers, but can do so best when it is able to work constructively with a community-focused hospital in common efforts to balance cost containment, quality and access issues in the broad public interest.

With such hospitals, Blue Cross Plans can strengthen and expand mutually supportive activities, and increase their visibility in the community. In developing this approach with an individual hospital, the Blue Cross Plan will build on its own systems capacity, hospital management expertise and Blue Shield relationships to help hospital management and medical staff leadership to attack cost containment problems and other hospital effectiveness issues vigorously and constructively in the public interest.

3. A primary focus on a "get tough" *adversary relationship* with any hospital providers which are aggressively resisting public pressures for reform. In some Plan areas, the adversary posture of some hospitals permits no other option for a Blue Cross Plan with commitment to the public interest. Some insurance commissioners, various unions and large corporations are highly concerned about the cost of health fringe benefits; they expect Blue Cross Plans to face up to any hospitals which want to explain away rising costs rather than attack real problems.

With "adversary" hospitals, a Blue Cross Plan has little alternative but to negotiate more strongly at arm's length and demand improved performance. Sensitivity to individual hospital problems, implicit in the interdependent Blue Cross Plan relationship, is not productive in relations with such hospitals. In fairness to their millions of subscribers, Blue Cross Plans must demand performance. As hospital performance standards are tightented, some of these hospitals may be expected to shift to non-participating status.

No One Option Fits All Situations. To be effective, an individual Plan's approach to its hospital relationships cannot be based on exclusive commitment to any one of these three options, by itself. The first option, the systems approach, is superficially attractive because it correctly stresses the importance of efficient service elements which are basic to any Blue Cross Plan role and can avoid much tension and friction with hospitals. Each of the three options must involve efficient systems, but this approach, by itself, is not sufficient because it ignores the opportunities inherent in the wide diversity of hospital and physician responsiveness to public pressures. Given the magnitude of current health care service problems, an agency with only a systems superiority has a weak claim to continued existence.

The second option, the interdependent approach, also cannot be effective if applied to all hospitals. This approach requires a degree of responsiveness on the part of the relating hospital that cannot be expected across-the-board in the foreseeable future.

The third option, the adversary approach, is also not feasible in relation to all hospitals. A Blue Cross Plan can no longer be partners with all hospitals, especially those with no visible dedication to the public interest. But little innovation will come from hostile relations with all. Such an approach assumes that the Blue Cross Plan has public support and that hospitals do not; in fact, Blue Cross Plans do not

have a monopoly in the pursuit of the public interest. There are outstanding examples of public-spirited trustees and hospital executives working hard to control costs, support community planning, improve utilization and test alternate delivery systems. Furthermore, despite clear evidence of consumer dissatisfaction, subscribers and public agencies at the local level are not united in any determination to achieve massive reform of hospital service; often quite the reverse is true when parochial interests are involved. Confrontation between "bad" institutions and "good" consumers most frequently reflects an oversimplified view of a complex situation.

Matching Options and Hospitals. These three options suggest vastly different behavior patterns for a Blue Cross Plan. Some Blue Cross Plans appear to have already made the choice, consciously or not, and are already following one or another of the three options outlined above — not always adequately tuned to the realities at each hospital. Each Blue Cross Plan should be prepared to exercise all three options in relating to different hospitals at different times. The key question is not "Which option?" but "Which option for which hospital at this stage of development?".

Different Blue Cross Plans can expect to have different mixes of hospitals in the three options, depending on the characteristics of (1) each hospital's leadership and medical staff, (2) the community served and (3) the capabilities of the Plan. Each Plan should strengthen its capacity to pursue each of the three options effectively at the same time and to make wise decisions in matching options and hospitals.

Nevertheless, Blue Cross Plans should have a preference for one of the three options which Plan spokesmen can articulate, and which consumers, the public and hospitals can identify as inherent in Blue Cross Plan-hospital relationships throughout the country.

Movement Toward More Interdependent Relationships. The thrust of this report is that each Blue Cross Plan develop the second option, the interdependent approach, with as many hospitals as possible. In some Plan areas, this might involve only a handful of hospitals at first. In other Plan areas, a much larger number of hospitals might respond more quickly.

Relations with most other hospitals can reflect the first option, an increasingly disciplined "systems efficiency" approach. With some hospitals, when necessary, the Plan must be prepared to adopt the third option, the adversary approach.

Adopting the second approach as the goal — broader interaction with hospitals based on interdependent responsiveness to community interest — has much to commend it to Blue Cross Plans, hospitals and the public. The relationship between Blue Cross Plans and hospitals is the main interface between money and health programs in the U.S., and effective interaction between money and programs is the key to solution of the nation's health care problems. The hospital-Blue Cross Plan relationship has accomplished much and is in place to be built upon; society does not have to create some new instrument for the purpose. Blue Cross Plan computer and data systems and skilled hospital relations staff form an essential base for a more dynamic relationship that can influence cost, access, quality and productivity of health care services. Many Blue Cross Plan officials have understanding of hospital problems and how they can be solved, and confidence of hospital officials and public representatives. Only 69 Plans are involved; much good leadership exists; and much strength is present. Each Plan can proceed at its own pace with each hospital, reflecting the degree of innovation, tension and competence in the local culture. Each Plan should accept the challenge, but all do not have to be leaders for national impact to be demonstrated.

Working together on an interdependent basis, a Blue Cross Plan and individual hospitals dedicated to the public interest can provide local demonstrations of a new approach to health care cost containment and reform that can enrich national public policy debates and suggest a new balance of constructive voluntary-public sector interaction at national, state and community levels.

Interdependent action between Blue Cross Plans and hospitals in the public interest cannot, of course, solve all of the problems acting in isolation from other national and community forces. Health Systems Agencies, PSROs, HMOs, Blue Shield Plans, hospital associations, state regulatory agencies and a host of other public, private and voluntary organizations have key roles to play in health care reform. All other forces for change will be handicapped in achieving results in the absence of interdependent Blue Cross Plan-hospital relationships, energetically supporting and underpinning their efforts. Any realistic approach must recognize that hospitals are where the action is — the professionals, the support personnel, the patients, the facilities, the money flow, traditional community leadership and emerging new community forces. Reform requires behavioral changes in this institutional setting.

Envisioned here is a true intermediary role for the Blue Cross organization: working with committed hospitals, consumers and government in the public interest, helping each to understand the other and maintaining confidence and effective communications with each. Is this possible or is there a conflict of interest? Many suggest that a Blue Cross Plan must decide whether it is provider or consumer oriented and believe it cannot be both. This is a wrong formulation of the problem; it is inherent in the Blue Cross concept to maintain strong bonds with the public and with public-spirited professionals and officials in hospitals as well. This has always been a keystone of Blue Cross philosophy and practice, and can be adapted to solve current problems.

The interdependent approach envisioned here rests on the belief that a Blue Cross Plan and a hospital can find much common interest in working together energetically to serve the community. However, there will inevitably be instances of conflict and friction. Blue Cross Plans will tend to be advocates for the well population and the entire community, whereas hospitals will quite appropriately focus on the needs of sick patients. Total agreement is not seen; there will be disputes with individual institutions at various times. However, the imperatives of providing consumers with quality care at reasonable cost with little paperwork through service benefits require constant interactions, effective working relationships and tested mechanisms for channelling and resolving conflict constructively.

In the environment of the seventies, a Blue Cross Plan must represent the consumer interest, but it can best do so by working closely with any hospitals that wish to identify with common public interest goals and by influencing all hospitals to face the realities of public service. The remainder of this report will attempt to outline ways that each Blue Cross Plan can strengthen its capacity to relate to hospitals in the public interest, develop more of a presence in health care delivery developments and shift more of its individual hospital relationships into the interdependent option. New attitudes and policies are involved, as well as new evaluation techniques, some reorganization and possibly allocation of more resources to this effort in most Plans. Hospital associations, Blue Shield, individual hospitals and their medical staffs as well as consumer and public agencies must necessarily be deeply involved; maximum success will depend on a common effort.

II. Elements of the Interdependent Blue Cross Plan-Hospital Relationship

Implementation of the interdependent approach will require that most Blue Cross Plans work at hospital relationships with renewed intensity. Current capabilities may have to be increased; new talent and new systems developed. Frequently, some reorganization of internal and external staff activities will be called for. The Plan's conception of its role in the community will typically be enlarged to encompass new programs aimed at aiding and influencing hospitals and their medical staffs wherever possible. Greater involvement with Blue Shield and other professional and public agencies will almost certainly occur. New ideas must be developed, tested and implemented.

This chapter attempts to lay out a structured framework for analysis of all facets of a Plan's hospital relationships, with special emphasis on transitional steps in moving toward a larger number of interdependent hospital relationships.

The heart of the relationship lies at the level of the Blue Cross Plan working with the individual hospital on a day-to-day basis in common service to the public. A well planned program, involving the following ten elements, should be productive:

1. Candor and credibility.
2. Interaction mechanisms.
3. Common philosophic framework.
4. Plan performance.
5. Hospital performance.
6. Joint programs.
7. Blue Cross Plan organization of its hospital relationship.
8. Hospital organization of its Blue Cross Plan relationship.
9. Blue Cross Plan involvement with agencies impacting on hospitals.
10. Visibility.

Candor and Credibility. A sense of mutual candor and credibility is certainly a key to an effective interdependent relationship. Unless there is a sense of understanding of and responsiveness to the other party's problems and pressures, the relationship is likely to be unproductive and probably harmful to the effort of both hospitals and Blue Cross Plans

to identify with the community. In the absence of this element, response to anticipated external forces will be, at best, unpredictable and, at worst, self-destructive.

A sound relationship recognizes the right — even the obligation — of both parties to criticize the other, not only in private, but also under appropriate circumstances in public. The relationship is one of candor and credibility between the parties and with the public. It is a relationship of shared goals and interdependence, but is not a partnership that precludes differences, private or public, about the community interest.

A productive sense of mutual trust depends upon the ability of Plan and hospital representatives to exchange information and to discuss problems in a framework in which the shared information will not be used for embarrassment. At the same time, the general rule of openness and public interest can never be forgotten. In general, the more the community knows, the better for all parties involved in community affairs. Few Plans feel sufficient obligation to share data that are valuable by-products of their hospital relationships. Fear of helping the "competition" frequently exceeds the obligation to let the public — or any part of it — know.

Interaction Mechanisms. Mechanisms for regular communication between Blue Cross Plan and hospital officials are crucial. In recent years, there has been a marked trend to reduce or remove hospital representatives from the board of Blue Cross Plans. A reduction or elimination of opportunity to participate at this level requires the sensitive organization of machinery operating at other levels to obtain hospital input.

A host of instruments is available as interaction mechanisms. During the visits made to Blue Cross Plans, we found the following used successfully:

Hospital Affairs Committees - At the board level with high level staff participation.

Hospital Advisory Committees - Created by the Plan and reporting to the board of the Plan, or to the Plan's chief executive officer.

Technical Advisory Committees - In addition to general hospital advisory committees, much can be gained from technical advisory committees' providing for input of fiscal officers, physicians, medical record librarians, outpatient staff, utilization review specialists, etc.

Blue Cross Plan Relations Committee of Hospital Associations - Plans usually are members of hospital associa-

tions and participate at the board and committee level, as well as at "district" levels of some associations. In addition, many hospital associations—both state and metropolitan—have special committees and councils concerned with the Blue Cross Plan relationship.

Appeal Mechanisms - Carefully designed appeal mechanisms which have the confidence of all concerned are important. Disagreements will inevitably occur and there should be remedies short of litigation.

Structured Agenda Liaison Meetings with Each Hospital - At least one Plan carries out a formal liaison meeting with each hospital at least once annually. In moving toward interdependent relationships, a Plan is well advised to develop this particular mechanism fully.

A Common Philosophic Framework. As Rufus Rorem, a pioneer in prepayment programs, once said, "What is the essence of the hospital-Blue Cross Plan relationship? Seller or buyer? Partners in public service? Producer and consumer? Brothers in the human family? Master and servant? Producer and/or consumer cooperatives?".

Historically, the strength of Blue Cross Plans, of hospitals and of their relationship has been deeply rooted in a common philosophic framework. Sharing a few basic concepts permitted subscribers to receive care at hospitals with little financial effort at the time of illness.

Little energy was expended by individual Blue Cross Plans or hospitals in the early, busy days in formulating precise statements of the common purposes and sense of mission on which the operating relationships were based. In many Plan areas, there is evidence that a few courageous, hard working, devoted leaders with a sense of mission and public interest shaped the relationship and carried the day with energy and results rather than with rhetoric or consensus exercises.

In more complex times, there are dangers in this approach. Lack of clearly stated concepts and basic principles can result in erosion of apparently strong ties. Too often, there is an apparent lack of vision. Managers are schooled in technical disciplines and quantitative techniques and can become preoccupied with them. The advice of lawyers and accountants may dominate the outlook of the chief executive officer. These viewpoints must be tempered by a community point of view of the broad public interest. Where is the field going? What does it believe in?

Although almost forgotten in some Plan areas and not clearly articulated in most, the philosophical fundamentals of a sound interdependent relationship have not changed:

- -A belief in pluralism in organization and financing of services the public requires.
- -Support of a flexible non-profit voluntary sector.
- -A commitment to community.
- -Concern with costs and efficiency.
- -Service benefits.
- -Commitment to the hospital as a continuing evolving institution with the potential to serve as a major organizing focus for comprehensive health care services and for balancing community and professional interests and aspirations.

A joint statement of philosophy, describing goals and working relationships, can be a source of strength to Blue Cross Plans and hospitals. As a public statement, such a document can be used over time to assess behavior against the spirit it contains.

Basic Plan Performance. There is no substitute for good performance. In its interactions with hospitals, a Blue Cross Plan must master computer and related technology and operate effective EDP systems. A Plan must get and maintain subscribers, process claims, answer the phone, etc. A good hospital relationship requires smoothly running Plan functions as they relate to hospitals. Money must flow in the right amount at the right time with a sensitivity to the extraordinary cash flow problems of hospitals. Audits must be done on time and with a sensitive interaction about exceptions. When operational problems develop, there must be ways to get after them quickly.

Several Plans have handled basic hospital services with great effectiveness through well trained provider representatives, special phone numbers and other devices. Plans are experimenting with direct hospital access to Plan files to permit eligibility verification. Blue Cross Plans and hospitals can work together on many more imaginative ways of using new technology; a few Plans are well along in developing paperless claims processing. But it is easy for a Blue Cross Plan to become too rigid and preoccupied with internal operational systems requirements and unresponsive to hospital problems.

Blue Cross Plans have yet to develop and publish reports of statistics which illuminate Plan performance from the

hospital point of view, similar to the performance standards designed for Medicare. Some of the performance standards in use within the Blue Cross organization go far in this direction. Those on eligibility response times and claims processing are directly relevant.

In the absence of systematic effort by a Blue Cross Plan to market its basic services to hospitals and their medical staffs, as it markets services to governmental and subscriber groups, there is frequently a lack of appreciation among hospitals of the effectiveness of Blue Cross Plan services. In many instances, Plans have a record of solid performance which is not documented and is further obscured by the tendency of some hospital fiscal officers to distort operating procedures and magnify the importance of isolated unfortunate events.

Thus far, we have not heard of any effort by Plans to develop techniques for evaluating Plan performance with active participation of contracting hospitals. However, a variety of technical hospital advisory committees does exist in many Plans which can be used for this purpose. A desirable by-product of such an effort might be the opportunity for hospitals to make accurate comparisons of Blue Cross Plans with other carriers.

Basic Hospital Performance. Hospital performance is at least as important as Plan performance to the public being served. In an effective relationship, the Blue Cross Plan can play an important part in a joint effort to define and measure effective hospital performance. The goal is that a subscriber-patient receive good service from both, at reasonable cost, with value added by the relationship.

At this time in the history of hospital-Blue Cross Plan relationships throughout the country, this is the weakest, least understood, most controversial and probably the most important of the elements.

Many hospital representatives appear to believe that basic hospital performance is none of the Plan's business. Some Blue Cross Plan executives seem to accept this point of view. Other Blue Cross Plan representatives appear to believe that a Plan can take major hospital cost containment initiatives without active top level hospital support or participation. The fact that some Plans do have some success under such circumstances clearly indicates the inherent power of the relationship and the amazing unused potential of a more dynamic relationship.

The public increasingly understands that 90 to 96 percent of Blue Cross premiums reflects hospital performance and medical staff decisions; less than 10 percent reflects direct Blue Cross Plan activity. Concern at Blue Cross Plan rate increase hearings may zero in on Plan executive salaries, reserves and overhead, but increasing attention focuses on the payments for hospital and medical performance — and what subscribers get for what they pay.

Rising expenditures for hospital service cannot be adequately explained in the absence of performance standards and clear-cut efforts to raise performance levels and standards with active involvement of the medical profession. Greater Blue Cross Plan initiative is called for in this type of activity.

To date, the hospital field has not developed systematic cost effective performance standards or programs designed to administer them, although the AHA's Hospital Administrative Services Program and some planning agency guidelines represent a good beginning. The standards of the Joint Commission on Accreditation of Hospitals offer a useful model, but have not yet addressed the issue. The AHA has come much closer to the basic questions in development of its Quality Assurance Program and Blue Cross Plans have developed imaginative joint programs with hospitals around Quality Assurance Programs. Much the same kind of thing can be done by Blue Cross Plans and hospitals with the current AHA initiative in promoting cost containment committees at individual hospitals.

Joint Programs. Given all of the above interactions between Blue Cross Plans and hospitals, joint programs are an inevitable consequence of an effective relationship. Good works, conducted together, demonstrate the validity of Blue Cross Plan-hospital relationships. In many areas, talented and aggressive hospital associations can be a source of energy and ideas.

The communities' institutions for providing care and the community institution for financing care may be independent of each other, but this does not preclude overlap and sharing of activity. Efforts to put the organization and financing functions in separate compartments can lead to sterility of relationship, missed opportunities and loss of public support. Blue Cross Plans can engage in a variety of joint programs with hospitals, over and above those functions that characterize a basic commercial insurance operation.

There are many examples of good joint programs — the CASH program in California, shared computer programs in Pittsburgh and many other Plans, prospective rate and incentive reimbursement experiments in several Plans, uniform billing forms, in-service training programs, HMO developments, shared methods engineering services and others.

But because this is a difficult area and can only come out of a relationship that is good in many other ways, there are few persistent patterns here and success tends to be isolated. Joint programs have probably not been regarded as an important goal of Blue Cross Plans or hospitals. But tremendous opportunities await the ambitious. Existing ideas can be elaborated and replicated. Innovation seems possible since little systematic attention has been given to this. With many Plans handling 50 or 60, even 80 percent of hospital money, can business operations be more coordinated with paperless claims processing and the resulting economies achieved? This could favorably affect a Blue Cross Plan's administrative costs and competitive position. Can hospitals and Plans and planning agencies get together and be forces of reason in support of coordinated public and private sector health development, as contrasted to massive government intervention? Can Plans and hospitals work together to develop health education for subscribers in the community, as well as for sick patients with particular disease problems? Can research be conducted jointly to learn more about the effectiveness of given delivery patterns?

Because organization, financing and administration of health care services are so bound up together, new ways will be found to link these various elements outside of Blue Cross Plans if the Plans do not take more initiative in demonstrating the value of joint programs with interdependent hospitals. There is already some tendency for functions which might stay wholly or partially within the relationship to move outside of it. New corporations to gather data are one example; PSRO is another; hospital planning is another; the rate setting commission is another. As planning agencies continue to evolve slowly or fail completely in some areas, a dynamic Blue Cross Plan-hospital relationship might find opportunities for renewed planning initiatives.

Destructive competition with active state and metropolitan hospital associations is to be avoided. Rather, hospital associations which wish to develop cost effective programs should be given assistance and support. But the ability of Blue Cross Plans to work with individual hospitals makes it possible for them to develop a variety of joint programs that the hospital association might not be prepared to initiate.

Blue Cross Plan Organization of its Relationships with Hospitals. All of the activities involved in Blue Cross Plan relationships with an individual hospital should be organized within the Plan in the most effective manner for marketing to member hospitals and for constructive impact on each hospital. This seems so obvious that it is easy to overlook. There is a wide variety of implications, each of which may result in minor or major adjustments in the organization of the individual Blue Cross Plan.

Often the quest for internal efficiency of Blue Cross organization elements can result in neglect of effective coordination of activities with individual hospitals. No short-term payoffs are seen and, in an effort to keep administrative costs down, the budgets for hospital relations suffer. Thus while the Plan's own administrative costs may look good, dollars represented by the share of the Blue Cross Plan premium going to hospitals may be rising rapidly, and with little restraint or influence from any Blue Cross Plan-hospital interaction.

We attempted to learn how many Plan employees and dollars are devoted to "hospital relations." However, there are few data available, and definitions which would permit comparisons do not yet exist. Better manpower and financial data are highly desirable, but an updated conceptual frame of reference will be required before the hospital relationship effort can be measured. The Blue Cross Plan dollar should be divided into three pieces rather than two. Instead of the traditional two-way split of the premium dollar between hospitals (95 cents) and the Blue Cross Plan (5 cents), there should also be separate identification of a quite thin third slice (a fraction of a cent). This slice would reflect Blue Cross Plan expenditures directly influencing hospital operations beyond what is necessary for basic insurance management. Identification of some fraction of a percent of premiums for this purpose can be sold to public and private markets when the potential impact can be seen in relation to the total expenditure.

A thoroughly developed hospital relations function will require change in most Blue Cross Plans; more personnel with hospital and health care service education and experience may have to be brought into the Plan structure. Often this will strain existing salary structures, since hospital salaries have been rising recently. But personnel employed can be counterproductive unless they command the respect of hospital leadership and are able to work with and understand their problems. Envisioned here is not a group of professional glad-handers spreading good will, but rather an active and energetic management of the hospital-Blue Cross Plan interrelationship. A large influx of expensive new people is not envisioned, but rather a few well qualified individuals who can help to coordinate and organize the activities of all Plan personnel involved in any way in hospital interactions.

Each Plan's approach to an interdependent hospital should involve an individualized plan for coordinating and expanding activities and furthering mutual public service goals, plus designation of a well qualified liaison representative for coordinating all Plan activities relating to each interdependent hospital.

Movement toward this kind of arrangement within a Blue Cross Plan inevitably creates certain pressures and tensions within the Plan which will require close attention by top level Plan management. The hospital relations specialists often become ombudsmen or advocates for the point of view of interdependent hospitals. As a result, there may be abrasiveness with other Plan personnel with a more internal focus and inability to distinguish among adversary, interdependent and uncommitted hospitals. But with appropriate balance provided by the Plan president, benefits of better organization of the Plan's hospital relationships can be significant, with improved performance from both hospital and Plan points of view of the public interest.

Relationships with hospitals and hospital associations, and the effort to maintain a Blue Cross Plan presence in the health community must be closely coordinated within the Blue Cross Plan. Usually one organization unit within the Plan will be the main focus of this effort, but functions will necessarily be spread among other divisions. There is no best way to organize a provider relations function; indeed a consciousness of provider affairs widely spread through the Plan is essential.

Hospital Organization of its Blue Cross Plan Relationship. The Blue Cross Plan is important to virtually all hospitals, even in low penetration areas. Almost every hospital in the United States receives at least half its income through the Blue Cross Plan, including Medicare and Medicaid payments. Even where the plan is handling three-quarters or nine-tenths of the institution's money, there are virtually no indications that any hospital executive has thought deeply about all of the elements of the relationship and organized the hospital management team to take advantage of the full potential of Blue Cross Plan interactions. But neither Blue Cross Plans nor hospital associations have suggested this approach to date.

A hospital committee might be formed, involving medical staff and board as well as management, to review the relationship on a continuing basis, to analyze strengths, weaknesses and opportunities. Reimbursement levels could be reviewed; Medicare policies discussed; scope of service reviewed in relation to benefit patterns; controls identified; or eligibility determination and payment cycles reviewed. Contrasting and sometimes conflicting pressures of consumers and professionals can be brought into better focus. If key personnel understood Blue Cross Plans better, it might help overcome the often simplistic references to third parties and their controls. Blue Cross Plan staff might be invited to attend selected hospital committee meetings. Assignments for ongoing liaison with Blue Cross Plans should be made, involving at least the chief fiscal officer and the chief executive officer. Such an activist conception of the Blue Cross Plan relationship by the hospital should improve performance under current programs and identify new areas where coordination could be beneficial.

Blue Cross Plan Involvement with Agencies Impacting on Hospitals. A Blue Cross Plan with effective relationships with hospitals will feel an obligation to become involved with a wide variety of health agencies in support of the public utility of the relationship. The Plan will have an important health presence throughout its enrollment area. The Blue Cross Plan will be active with a variety of voluntary and governmental agencies which affect or are affected by the organization and financing of hospitals: United Funds, HSAs and other areawide planning agencies, Blue Shield and a variety of medical societies and other associations of professionals, health data system agencies, PSROs, state regulatory agencies, Medicare, Medicaid and other governmental programs, etc. Relationships with hospital

associations and participation in their affairs will be an area of special focus. In each instance, the Plan will be alert to assure that these health agencies know of the significant community interest dedication that a sound hospital-Blue Cross Plan relationship represents. In addition, the Blue Cross Plan will be alert to ways in which these health agencies can be supportive and make maximum use of the relationship in carrying out a wide variety of functions related to improved effectiveness of hospital service. By this means, the Plan can save individual hospitals a great deal of duplicate and unnecessary work with these agencies.

Visibility. A healthy Blue Cross Plan-hospital relationship, in which separate accountabilities are preserved but interdependence is recognized, should be public information. Everyone should know how a Plan and a hospital are helping each other do the best possible job for patients, subscribers and the community.

The goal of the interdependent relationship is improved capacity of both parties to serve the public. Achievement of that goal requires that the public know the facts and be able to evaluate the results.

In addition, both the Plan and the hospital should publicly reflect their belief that interaction between the community's hospital service and financing agencies can serve the public interest and can help to improve the overall health care system locally and nationally.

Visibility of the interdependent relationship should be incorporated into all formats through which the hospital and Plan communicate with the public. Joint conferences of Plans and interdependent hospitals with representatives of important subscriber groups and public agencies are especially important.

An effort to concentrate on the goals and results of the interdependent relationship might move critics away from discussions of whether the relationship is too close or distant and toward consideration of how well it works for the people.

Conclusion

Taken together, these elements lay out a major new emphasis for Blue Cross Plans with far-reaching implications. Some specific recommendations to these ends are made in Chapter IV. The task will be difficult and tax the energy and vision of all Blue Cross Plans. Major work with hospitals is envisioned, carried out in a context of public accountability. Successes with interdependent hospitals will lead to policy shifts at previously uncommitted "systems oriented" hospitals and at "adversary" hospitals. As progress is made, subscribers, insurance commissioners, legislators and others must know about the effort and its implications. A few simple ideas are the core of it, but they have great potential for addressing almost every important issue in health care. Mistakes will be made but the time is right for new directions. An interdependent Blue Cross Plan-hospital relationship does not represent "the answer" to cost effectiveness problems, but offers an approach that is reasonable and that can be evaluated and measured over the years.

III. Views of the Blue Cross Plan-Hospital Relationship

In the course of our investigations, we encountered a variety of reactions to the concept of an interdependent Blue Cross Plan-hospital relationship designed to serve the public interest. Almost every reaction was closely related to personal viewpoint about (1) the nature of the nation's health care problems and feasible solutions, (2) the future role of the voluntary hospital, and (3) the future balance between the public and voluntary sectors of the nation's evolving health system. Efforts to enhance the effectiveness of interdependent Blue Cross Plan-hospital relationships must anticipate and prepare for these reactions.

Hospital Associations. The official position of the American Hospital Association, developed in conjunction with the BCA and adopted in 1972, is strongly supportive of interdependent Blue Cross Plan-hospital relationships designed for joint action in response to pressures for increased productivity and accessibility to care (see attachment at end of this chapter). The policy statement emphasizes that "the delivery of health care is basically a local matter and that service without financing and financing without service are both impossibilities. Meaningful solutions, therefore, can only be achieved through joint action at the local level . . . The future strength of the voluntary system of service and finance is dependent upon its ability to respond positively . . . and demonstrate significant progress . . . It is recommended that joint Blue Cross Plan/hospital mechanisms be developed for assisting, along with other appropriate community organizations, in defining problems and identifying, implementing and evaluating potential solutions."

The statement indicates that joint Blue Cross Plan-hospital action can serve "not only to resolve local problems . . . but also to integrate the service and financing arms of the private sector into a force capable of resolving complex issues of concern nationally."

This same official position was adopted by the BCA Board of Governors, as one follow-up to the 1971 joint memorandum on "AHA-BCA Organizational and Operational Relations".

Unfortunately, a series of distractions (national price controls, gap between leaders, etc.) interfered with implementation of the American Hospital Association's position, which has not yet been actively promoted through metropolitan and state hospital associations, or interpreted to association member hospitals in terms of operational implications for them. Many individuals associated with the AHA appear to support a purely systems approach and avoidance of any distinction between hospital relationships of community-based Blue Cross Plans and national commercial carriers. Implementation of the official position is long overdue, especially in view of the current initiatives of the American Hospital Association in hospital cost containment.

State and local hospital association executives tend to reflect a wide variety of reactions to the concept of an interdependent Blue Cross Plan-hospital relationship, based on their understanding of the AHA's direction as well as the pressures in their particular association area. Some newer association executives tend to be more committed to an expanded role for state government in direct controls rather than dynamic interaction with Blue Cross Plans in response to public pressures. Most recently, however, some disillusionment with the rigidities of government regulation seems to be setting in, which may open opportunities for reassessment of Blue Cross Plan relationships. In many areas, long-standing good relationships between Blue Cross Plans and hospital associations exist and have served the community well. A few of these, faced with tremendous social pressures, are experiencing difficulties in the absence of systematic assessment of interdependent goals by the hospital association and the Plan.

Hospital Executives. In our discussion with individual hospital executives, we observed tough-minded assessment of the Blue Cross Plan relationship based on the Plan's systems performance and its demonstrated understanding of and responsiveness to individual hospital problems. The extent of sensitivity of hospital managers to external pressures for change and recognition of the necessity to respond was greater than anticipated. Individual hospital executives typically viewed their Blue Cross Plan in a favorable light and, when stimulated to think about future health system developments, many readily accepted the idea that Blue Cross Plans should move into new roles in NHI, for example.

Only a few strong-willed executives espouse an adversary approach; but some prefer the neutrality of the systems approach. Many fear that the Blue Cross organization is becoming an agent of government. At the same time, there are sufficient influential and capable hospital leaders who respond positively—even enthusiastically—to the concept of a more active interdependent Blue Cross Plan relationship to suggest real potential for success of this approach. These executives see sensitive Blue Cross Plan interaction as essential to internal reform required for more effective community service by their hospitals. A number of influential hospital executives are critical of the local Blue Cross Plan for dragging its feet on new approaches to delivery of medical care, for being slow to expand ambulatory and out-of-hospital benefits and for not being tough enough with other hospitals concerning excessive duplication of facilities.

Blue Cross Association and Plan Executives. Most Blue Cross organization executives, like hospital executives, are not aware of the 1972 policy statement adopted by the BCA and AHA in support of the interdependent hospital-Blue Cross Plan relationship at the local level. They understand the necessity to follow all three approaches — systems, interdependent and adversary — with general recognition that a total adversary relationship can only presage the demise of voluntary initiatives in the organization and financing of health service. There is unusual awareness of the strong forces currently affecting health care services and recognition that weak technical systems must be strengthened to maintain competitiveness in public and private programs. Plan executives also increasingly recognize that Blue Cross Plan obligations in cost containment and effectiveness go far beyond mechanical systems. There is interest in the individualized interdependent hospital approach, but much concern about (1) how to meet allegations of favoritism and of getting too close to the hospitals, and (2) how to justify the costs of more direct involvement in hospital programs. There is also desire for more practical guidance from the BCA and AHA in working with hospitals.

Other Observers. An alarming number of external observers of the health care field with whom we spoke — academicians, government administrators, union officials, community leaders and specialists in public policy — appear to have dismissed voluntary initiative as an important factor in

solving current health care problems at this time. This point of view was all the more striking because so many of these observers reflected deep commitment to voluntary action at the community level and to citizen participation to solve other social problems. Despite a general skepticism about government regulation and the federal bureaucracy in particular, there is a marked tendency to look to strong governmental action to control hospital costs and bring about organizational changes in the field of health and medical care. Although many public and consumer spokesmen are exerting strong pressure on Blue Cross Plans to "get tough with hospitals," they appear to have little confidence that confrontation between voluntary agencies in the health field can produce significant results.

Virtually all observers are convinced that hospital costs are rising at an unacceptable rate and that steps must be taken to contain costs. There is little consensus about specific solutions and no suggestion of politically feasible approaches to the problem at the disposal of government. There is general recognition that the costs of health services cannot be shifted to the patient or the consumer and that normal marketplace forces cannot work effectively with respect to health services.

The current thrust toward governmental initiative in health care service reform seems to reflect a sense of frustration and a lack of alternatives rather than any strong commitment to governmental programs as such.

Most critics and reformers of the hospital field tend to see Blue Cross Plans — along with other third party payers — as part of the problem rather than part of the solution. Among the various observers of the health field with whom we explored the problem, none had seriously considered the alternative proposed in this report: *dynamic cost containment and cost effectiveness interaction between a hospital and its Blue Cross Plan, operating under the watchful eye of existing state and federal government regulatory agencies which already control Blue Cross Plan, Medicare and Medicaid rates and hospital programs.*

Most observers outside of the hospital field — when exposed to the rationale for the interdependent Blue Cross Plan-hospital approach — remained skeptical, but some became quite enthusiastic and many indicated interest in learning more about the idea. Most realize that there are no easy solutions and that government has no ready answers to the cost problem that would not threaten quality or accessibility.

Many governmental officials tend to think of Blue Cross Plans as "too close to the hospitals" and are surprised to learn that many hospital officials see Blue Cross Plans increasingly as an agent of government. The wide diversity among hospitals is partially understood, but few officials have yet recognized that almost all generalizations and generalized approaches to hospital problems have limited value.

There is reason to believe that most responsible public representatives and spokesmen — with sufficient exposure to the facts — can face the hard reality of health care reform: There is no substitute for slow, hard work to change fundamental professional and patient behavior at the hospital level. Workable techniques for cost effectiveness will be developed and tested in the hospital setting — hospital by hospital — starting with those most ready to respond to the public's demands. And the Blue Cross organization is the agency which has the capability, incentive and relationships to work with these hospitals and lead the nation to a more disciplined effective health care system. This is the difficult — but optimistic — message which BCA leadership can bring to the national debates about health care reform. This is an answer to the cost containment problem — one that can work in every community in the nation — which is sensitive to quality, access and effectiveness issues. But BCA will require more real examples of solid and successful cooperative effort between publicly responsive hospitals and their Blue Cross Plans if this message is to have impact. Otherwise, the Congress and state legislatures may be caught up in yet another short-lived, simplistic and frustrating "answer".

Time may be short. Each Blue Cross Plan can begin now to increase its expertise in working with — not against — any hospitals which show an interest in cost containment and community service effectiveness. The number of individual hospitals which will voluntarily and sincerely work with Blue Cross Plans — as an effective alternative to direct governmental intervention — may surprise those who do not recognize the special form of public interest commitment reflected deep in the traditions of many voluntary hospitals.

Given a mobilized public opinion and pragmatic governmental regulatory agencies, hospital response to Blue Cross Plan suggestions for an interdependent relationship may demonstrate the essential and lasting social value

of an ever-evolving hospital-Blue Cross Plan relationship. Each Blue Cross Plan is well advised to move in this direction—with all deliberate speed — reflecting the changing environment in each Plan's region.

Blue Cross Plan-Hospital Local Relationships

Approved by Joint AHA-BCA Committee - October 11, 1972
Approved by BCA Board of Governors - November 13-14, 1972
Approved by AHA Board of Trustees - November 17, 1972

The lever of technological and social change is moving both Blue Cross Plans and hospitals into previously unexplored roles and relationships. Pressures to increase productivity and accessibility to care are being felt at both the local and national levels and are being reflected in not only innovative programs, but also in a restructuring of traditional accountabilities.

The challenges and demands for change cannot, however, be ignored. While change may perhaps at the outset replace familiar relationships with short-term uncertainty and strain, inaction is an open invitation to the external imposition of simplistic and inappropriate solutions to the complex issues which face the health care system. The future strength of the voluntary system of service and finance is dependent upon its ability to respond positively to these challenges and demonstrate significant progress toward their solution.

As the voluntary system seeks to meet the demand for change, it must be recognized that the delivery of health care is basically a local matter and that service without financing and financing without service are both impossibilities. Meaningful solutions therefore, can only be achieved through joint action at the local level.

Hence, it is recommended that joint Blue Cross/hospital mechanisms be developed for assisting, along with other appropriate community organizations, in defining problems and identifying, implementing, and evaluating potential solutions. These mechanisms should also serve as one vehicle for providing local input into the national process of establishing policy and setting goals.

Blue Cross and hospitals both must advocate the needs of their respective constituencies. Such advocacy must not be allowed, however, to negate the operational relationship which has long been vital to both their mutual and individual strengths. A joint communication vehicle, whether in the form of ad hoc committees, standing committees, joint board representation, periodic meetings, or whatever is appropriate to the local situation, is needed. The joint communication mechanism can serve not only to resolve local immediate problems at their formative level, but also to integrate the service and financing arms of the private sector into a force capable of resolving complex issues of concern nationally.

IV. Recommendations

Recommendations are presented in three sections: A) to the Blue Cross Association, B) to Blue Cross Plans, and C) a brief note to hospital executives.

Recommendations to the Blue Cross Association

1. The Blue Cross Association should develop an updated policy position on Blue Cross Plan-Hospital Relationships.

Historically, Blue Cross Plans and hospitals have had an interdependent relationship which has been mentioned in a variety of policy statements over the years. The relationship has been changing, both nationally and at the level of individual Plans. Today, no authoritative policy statement exists which reflects current Blue Cross Association concepts and aspirations concerning hospital interaction. A 1971 memorandum on "AHA-BCA Organizational and Operational Relations" contains an outstanding analysis and calls for a "more dynamic relationship," but it is concerned exclusively with Blue Cross Association relationships with the American Hospital Association rather than with Plan-hospital relationships. The 1971 memorandum was never circulated widely, has been poorly understood and falls short of a total statement of policy. The 1972 AHA-BCA "Statement on Blue Cross Plan-Hospital Relationships" calling for local efforts "to integrate service and financing arms of the private sector" is excellent, but has not been widely discussed.

The Blue Cross Association should reaffirm its commitment to an interdependent relationship with hospitals which share community service goals and dedication to the public interest. A major policy statement is envisioned, detailing the implications of interdependence for Blue Cross Plans and participating hospitals in a period of health care delivery system reform, an expanding public sector and an increasingly hostile environment concerning expenditure levels and hospital self-determination. The policy statement should be widely promulgated to hospitals, government, the medical profession and the general public. Complex issues must be dealt with, including cost containment, the effectiveness of hospital services, public-private sector relationships and

balance, hospital-physician and Blue Shield relationships, the role of the hospital in organizing community health care, the scope of hospital service (e.g. any service performed at, within or under the surveillance of a health care agency known as a hospital), reimbursement issues and a host of other factors. The task involves review of existing policy and reformulation in a new framework. This overall statement should make clear that BCA positions on public policy questions will be implemented flexibly on a Plan-by-Plan and hospital-by-hospital basis.

Development of the policy statement could take a variety of forms and evolve from presidential papers and from task forces related to the Board of Governors. The statement might be completed and released in parts over a period of time. Involvement of AHA and hospital officials in the formulation of the policy statement is desirable and could also take various forms.

2. The top leadership of BCA must play the key role in developing, promulgating and implementing the policy statement on hospital relationships.

The policy statement and related recommendations described in this chapter have significant implications for the future of Blue Cross Plans. Difficult and highly charged issues must be faced within the Blue Cross organization, and externally with hospitals, hospital associations, Blue Shield, national government, the professions, media, etc. Only a major effort of the president of the Blue Cross Association, with support and active participation of the Board of Governors, Blue Cross Plans and Blue Cross Association staff is adequate to this task. The entire process will necessarily extend over a period of years of evolution and adaptation.

3. BCA should develop an improved capacity to provide assistance to individual Blue Cross Plans in development of their hospital relationships.

With the statement of policy and continued refinement of the ten-point framework of Blue Cross Plan-hospital relations shown in Chapter II, the Blue Cross Association should develop an improved capacity to assist individual Plans in reshaping their hospital relationships. This

involves understanding of the complex interplay between the influence of local and national forces on the relationship of each Plan with individual hospitals in its area. Such understanding should be reflected in the Plan Performance Review Program as well as other staff activities of the Blue Cross Association.

Different Plans can be expected to encounter (1) different mixes of interdependent, adversary and systems-oriented hospital relationships, (2) different types of opportunities with their interdependent hospitals, and (3) a variety of challenges in attempting to find common grounds for shifting various hospitals from systems and adversary relationships toward interdependent relationships. BCA staff should be in a position to provide perspective and guidance to an individual Plan on the overall shape of its hospital relationships as well as on specific aspects.

At least a half dozen top BCA executives should assume responsibility (along with their other duties) for continuously keeping in touch with hospital relationship developments at a selected number of different Plans. These BCA executives should be in a position to mobilize national resources and information to help the Plans in their efforts to carry out BCA policy.

The primary Blue Cross Plan-hospital relationship is at the local level where it is the responsibility of the individual Blue Cross Plan. The thrust of this recommendation is for BCA to develop greater capacity to anticipate and respond to requests for assistance from individual Plans in designing strategies for change consistent with BCA policies and the Plan's traditions, talents and unique environment.

The Blue Cross Association should incorporate the concepts of the ten elements of the interdependent hospital relationship into its Plan Performance Review Program to encourage adequate effort and BCA awareness of innovation at each Plan.

4. A major communications program will be necessary to consult with and inform all elements of the public about the Blue Cross Association's basic policy with respect to hospital relationships, and its full implications.

Blue Cross Plan subscribers, other consumers, hospitals, the Congress, major accounts, the medical profession, Blue Shield and others all should know about and contribute to understanding of Blue Cross Association policy and programs with respect to hospitals. A major communications effort will be required to identify Blue Cross Association policy with the public interest.

Only an intense communications effort will lead to public and professional understanding and support of the complexity of the Blue Cross organization's task involved in adapting public interest goals to the wide variety of hospital settings in which subscribers expect to receive care. In many situations, clear evidence of public support of the interdependent concepts will be the key to shifts in viewpoints within individual hospitals. Furthermore, public understanding of the complexity and time involved in demonstrating results of a new interdependent hospital relationship is essential.

The outcome of an effective Blue Cross Plan relationship with interdependent hospitals is so important that false expectations should not be encouraged. There are no easy answers, no quick solutions, no real solutions to hospital cost and effectiveness problems that do not involve basic changes in deeply rooted behavior patterns of consumers and professions at these institutions — hospital by hospital.

The Blue Cross Association has the extremely difficult assignment of simultaneously helping the public and policymakers to understand (a) that easy, fast and simple solutions are dangerous and (b) that interdependent hospital-Blue Cross Plan relationships dedicated to reform at the community level represent the most promising new idea that can produce safe and sound results in the long run. Any concrete demonstrations of the practical results of such interdependence greatly eases the task in spreading the word. The BCA communications effort involves its own set of interdependent actions. Concrete results will be hastened by public understanding; so too, public understanding will be hastened by demonstrations of concrete results. Neither can wait for the other; both must proceed simultaneously.

5. BCA should work with the American Hospital Association in a common effort to promote interdependence of Blue Cross Plans and individual hospitals dedicated to the public interest.

The 1971 statement, which addressed AHA-BCA organizational and operational relations, has been reconsidered recently and changed only in minor ways. The specific steps outlined should continue to be energetically pursued. For example, the Joint AHA-BCA Committee should continue to meet and be a key forum for discussion of issues.

But the relationships between BCA and AHA will not be revitalized until both organizations begin to act energetically and independently to strengthen the relationships between their respective constituencies in their efforts to serve the public at the community level.

A dynamic, public interest-oriented relationship at the national level can be a credit to both organizations; their individual prestige and influence — on their members and the entire national scene — can be enhanced. Together, BCA and AHA can set the tone for relationships between Blue Cross Plans and hospital associations throughout the country by demonstrating the value and methodology of interdependent dedication to the public interest.

Blue Cross Association relationships with the American Hospital Association should not differ significantly from American Hospital Association relationships with commercial insurance organizations that are able to reflect the same commitment to interdependent community hospital relationships as reflected in the 1972 AHA-BCA policy statement. By the same logic that dictates markedly different Blue Cross Plan relationships with interdependent and other hospitals, so too the American Hospital Association can be expected to reflect different relationships with third party agencies committed to community prepayment discipline and those which are essentially insurance oriented.

6. BCA should explore and experiment with additional methods of obtaining hospital input into the Blue Cross Association policymaking process.

More hospital involvement in Blue Cross Association policy formulation is desirable. While the AHA relationship is important, the hospital members of the Joint AHA-BCA Committee are extraordinarily busy and must inevitably reflect not only official AHA policy, but the wide spectrum of views within AHA membership. This level of relationship at the national level is necessary but not sufficient.

Blue Cross Association should take steps — through the Plans — to enlist the help of hospital executives who are deeply committed to an interdependent Blue Cross Plan-hospital relationship in the public interest. This would permit interaction over time among a knowledgeable group of hospital executives who understand Blue Cross Plan problems and pressures intimately, and can give sage and sensitive counsel. This additional input could be achieved in various ways through a high-level hospital advisory committee or through participation on BCA committees and task forces by selected hospital executives who have solid records of performance with individual Plans.

7. BCA should enlarge its capabilities to play a "clearinghouse role" with respect to hospital relations.

Many Blue Cross Plans are eager for the BCA to play a more sensitive role in assisting them in dealing with specific aspects of the hospital relationship. Many Plans have achieved impressive gains which are not well known and understood around the organization. BCA should have more complete information and analysis in the following areas, for example: Blue Cross Plan-hospital contracts, mechanisms for hospital input into Blue Cross Plans, relationships with hospital associations and details of the formal and informal processes involved in changing hospital contracts. BCA staff should be well versed not only in substantive issues and in the use of various tools, but also in the dynamics of local change processes. Communications among provider relations staff in Blue Cross Plans can be more effectively organized on a formal and informal basis. A national conference of several days' duration might be a kick-off step. Currently there appears to be little com-

munication among Plans concerning provider relations processes other than the annual conference at the American Hospital Association convention.

Clearinghouse activities do not usually function effectively if based only on a library approach of collection and exchange of documents. Those involved in managing the clearinghouse must have field experience, field contacts and sensitivity to the settings in which problems are identified and solved.

8. BCA should attempt to carry out, sponsor and stimulate more research and demonstrations on hospital-Blue Cross Plan relations.

There is currently little research or academic interest in defining and evaluating hospital-Blue Cross Plan relationships. Recent literature on this subject is minimal in relation to its importance. BCA should attempt to do more work on this through its Research and Development Division and the Health Services Foundation. Steps to stimulate government and foundation interest in sponsoring and financing studies and demonstrations in this area should also be taken.

The following are examples of analyses which might be undertaken:

- "Case history" material from individual Plans of specific jointly sponsored "hospital effectiveness" programs.
- Various forms of hospital input into Blue Cross Plan policy formulation, planning, evaluation, development and review of procedures.
- Hospital payments under the Medicare formula compared with what the payments would have been if the service were under the "regular" Blue Cross reimbursement contract.
- Formal and informal processes for changing the hospital contract.
- Research and development activities of individual Plans which involve hospitals.
- Services provided by individual Blue Cross Plans to hospitals — computer, public information, consultation in methods engineering, other types of consultation, collection service, auditing, fund raising, etc.
- Involvement of hospital medical staff members in Blue Cross Plan affairs.

-Involvement of individual Plans in health data systems.
-Involvement of individual Plans in PSRO activities.
-Cost and results of programs of Blue Cross Plans to contain costs and improve hospital effectiveness.
-Applicability of a variety of hospital performance standards in assessment of individual hospital effectiveness.
-Effective joint Blue Shield and Blue Cross Plan programs in relation to medical staff activities of specific hospitals.
-Relationships between Blue Cross Plans and multi-hospital corporations.
-Blue Cross Plan involvement with hospital closings, mergers, affiliations and regionalization efforts.
-Blue Cross Plan Interactions with a variety of hospital outreach programs, hospital based group practices, health education programs, etc.
-Differential characteristics of Blue Cross Plans and Plan areas with different mixes of interdependent, adversary and system-oriented hospital relationships.
-Differential characteristics of hospitals and hospital communities with different types of Blue Cross relationships.

Recommendations to Blue Cross Plans

The burden of strengthening hospital-Blue Cross Plan relationships in the public interest necessarily falls on the individual Plan, with its community focus and intimate knowledge of each hospital's potential assets and liabilities. The general thrust of this report suggests a variety of moves by every Blue Cross Plan now and in the future to serve the public better by developing more effective relationships with hospitals. The recommendations listed below have far-reaching implications for every Blue Cross Plan and for the future of the Blue Cross organization as a public service institution.

1. Every Plan should take immediate steps to move toward an individualized relationship with every hospital.

Every Plan — no matter if it is large or small, whether it pays costs or charges, is in a low or high penetration area, whether it offers limited or extensive benefits, or whatever — should begin immediately to achieve an appropriate individualized relationship with every hospital in its area.

Data on every hospital, currently located in various operating units throughout the Plan, should be coordinated and organized to provide a unified and comprehensive view of each hospital. Who are the board members? What are the medical staff relationships? Are certain enrollment groups or spokesmen closely identified? What are the key cost and utilization data? Does the hospital have capital plans? What is the reaction of the planning agency? What are the internal and external problems of the institution? How sophisticated is the management; and how secure? Can the Blue Cross Plan help — either by itself or in conjunction with other agencies?

This approach calls for:

a) An individualized, coordinated *plan of action* to strengthen the relationship with each hospital in fulfilling the Plan's goals, and a process for carrying out this plan, evaluating progress and continuously updating the plan.

b) Assignment of Plan executives who are responsible—whatever their other duties might be—for the continuous *management and monitoring of the hospital action plan* for a given number of institutions. In all likelihood, one Plan executive cannot monitor, evaluate and guide the improvement of service for more than ten hospitals.

c) An annual top level *"structured agenda" liaison meeting with each hospital* — involving management, trustees and medical staff — to review relationships. Most hospitals with a medical school affiliation have such an annual liaison meeting. Certainly, liaison with the Blue Cross Plan which provides over half of the hospital's income is no less important.

d) A well qualified representative of the Plan to serve as the *overall Plan point of contact for the hospital*, and as coordinator of all Plan relationships with that hospital. This individual should be responsible not only for coordinating hospital-Plan relationships within the Plan, but also for coordination of Plan activities with external agencies in relation to that hospital (such as planning agencies, subscriber councils, physicians, Blue Shield, other providers, etc.).

e) Assignment of the *overall management of all hospital relationships* to a senior vice president responsible for all provider relationships, including the Plan's "presence" in the hospital and provider community. All Plan functions involved in the hospital relationship cannot be under his direct management (EDP, PR,

etc.), but he must be in a position to assure the coordination of these resources in a manner that simplifies the job of marketing the Plan to each hospital, and of having the greatest impact on each hospital.

f) All of this should take place within an *overall Planwide Provider Relations` Policy and Program* which integrates the individual hospital relationship, hospital association relationships, Blue Shield relationships and liaison with other providers and health agencies into a single effort.

This kind of ongoing review — with Blue Cross Plan executives assigned responsibility for each hospital — will do much to identify problems and opportunities which may not currently be known to the Plan and hospital.

Organizing and coordinating the total Impacts of a Plan on a hospital can permit Blue Cross Plans to have substantive impact on the evolution of every hospital — its costs, utilization and services. Many hospital trustees and executives will welcome an ally in the battles involving inflation, technology and allocation of scarce resources. Cost containment, for example, can be a lonely, thankless task in an individual hospital where income maximization has been the primary fiscal approach.

Individualizing hospital relations may not always improve them. Hospitals which pursue a self-serving course at the expense of an effective delivery system at other hospitals will not be an asset to the Plan. Plans should contract only with hospitals which share their community goals — or at least do not oppose them. Adequate freedom of choice of hospital and doctor must be preserved, but this will rarely require contractual relations with adversary institutions.

2. Every Blue Cross Plan should re-examine the overall organization and management of its hospital relationships and formulate a short and long-term improvement program.

In almost every Plan, implementation of the first recommendation — individualizing the hospital relationship – will require some reorganization of Plan activities involving nospitals. In view of the diversity and complexity of the issues, it is not possible to lay out a specific set of recommenda-

tions applicable to all Blue Cross Plans. Every Plan, however, can improve, and should conduct a self-analysis of its role in the delivery system and its hospital relationships.

The range of response among Plans can be expected to vary widely based on a variety of local factors, including market penetration, status of government business, goals of key buyers, strengths and weaknesses of PSROs, HSAs and other local agencies. The national point of view and the value of organizationwide credibility must be adapted to these local variables. Each Plan will develop its own policies, governing its efforts to affect the total delivery system by stimulating individual hospitals.

The outcome of the individual Plan's appraisal should be an identification of strengths and weaknesses and an action plan with a series of goals and tasks identified, target dates established and accountabilities made clear. Such a plan should be updated periodically in accord with corporate planning processes. Hospital representatives must necessarily be involved in certain facets of the effort.

The ten elements of the interdependent Blue Cross Plan-hospital relationship defined in Chapter II contain a set of ideas which can aid self-evaluation. Some general comments can be made in that framework.

Candor and Credibility. While it is impossible to quantify this variable, certain aspects of it can be identified. The role of the Plan president is crucial; he must give hospitals his own time and have a sincere desire to bring public-spirited hospitals into the life of the Plan.

The president sets the tone and animates the provider relations staff. If he works at it, over a period of years he will reflect an understanding of hospital problems in serving public, professional and institutional interests. He and his organization will interact well with hospitals and their organizations in daily business dealings and in discussions of basic issues. A secretive approach that does not seek opportunities for communications can only breed misunderstanding and distrust.

Each hospital executive must feel that he or she has high level access to the Plan on questions facing the individual hospital. To maintain a sound relationship, any question will be handled fairly on the basis of the facts, with a sense of due process, dedication to the public interest and a feeling that at least there is full understanding of the hospital's unique problems. Among agencies with which hospitals

relate, only Blue Cross Plans have the potential of developing an understanding of each institution and the flexibility to provide required resources in a disciplined way.

Interaction Mechanisms. In our Plan visits, we saw potential problems in a number of Plans involving this element of a sound relationship. We saw longstanding interaction mechanisms which were ineffective or had fallen into disuse. Board level committees for hospital involvement sometimes had not met or were poorly staffed. In two cases, the contract — the basic instrument defining the relationship — was clearly out-of-date and key parts of it were ignored. If substantial problems develop, the potentials for trouble are large.

It seems desirable for Plans to maintain several mechanisms for communications and problem solving. This seemed to be the case in circumstances where the relationship was most open and productive. Relationships must work at a number of levels in the Plan and with hospitals. The Plan board, executives and working staff all have roles to play. Hospital organizations must be dealt with on important policy issues. A myriad of operating problems requires relationships with various executive and technical personnel within hospitals.

Mechanisms should be in place to exchange communication on policy, routine problems and unusual problems and to handle potential crisis situations. Some combination of advisory committees, appeal mechanisms, a well trained provider relations staff and regular conferences of technical people must be blended with informal and personal associations to meet local circumstances.

Hard work is required to keep the mechanisms active and useful.

Common Philosophic Framework. A statement of common philosophy, goals and mutual obligations of community service ideally should be the formal base of an effective relationship between a hospital and its Blue Cross Plan. Such a statement will relate basic concepts to the forces impacting on hospitals and communities in the 70s and 80s and help to formulate fresh solutions that can be found only in stronger linkage of community organization and community financing of hospital service. While the rhetoric in itself is not important, a statement of principles can be a useful reference point and guide to behavior. It can help to overcome drift and bickering among the technicians. A document might be developed that is a statement to the community;

language might be incorporated in the Plan-hospital contract; or even be a part of the by-laws of the Plan. A well written statement of common commitment can be viewed as a source of pride and strength.

The process by which the statement of common philosophy is developed and updated may be more important than its substance at any given point in time. Furthermore, a statement of common philosophy does not have to be accepted by or acceptable to all hospitals — only to member hospitals. The process of continuously updating a statement of common philosophy can help the public to identify the degree of dedication to public service of Blue Cross Plans and hospitals which meet ever rising standards of community service.

Plan Performance. As part of an overall effort to develop performance standards, Plans should develop measurements in key areas which influence providers such as eligibility verification, claims processing time, cash flow, etc.

Hospital involvement is important. Data can be gathered at the institutional level to compare the performance of Blue Cross Plans with government programs and other carriers. Blue Cross Plan uniqueness (or lack of it) should be illuminated in the minds of hospital executives.

Studies could be undertaken to document the extent of savings to hospitals which accrue from a Blue Cross Plan's simplified administrative arrangements. Unique Blue Cross Plan services to hospitals can be identified. Opportunities for administrative efficiencies and improved system design might be discovered that will lead to lower Blue Cross Plan and hospital administrative costs.

A Blue Cross Plan should be prepared to provide specific details of the full value of its relationship to the leadership of each hospital, relating to concrete situations involving the hospital.

Hospital Performance. AHA policy on the Blue Cross organization has recognized the joint concern for hospital performance standards for many years and a continued strong national AHA initiative is bound to be helpful. But individual Blue Cross Plans are well advised to take their own initiatives in cooperation with member hospitals in stimulating systematic approaches to evaluating and improving hospital performance in the areas of cost and quality. Subscribers increasingly expect it, and the Plan has certain perspectives and capacities which give it unique abilities. There are a number of facets of this:

1) Certain requirements can be embodied in the contract. These would tend to go beyond basic JCAH type standards of safety, organization and facilities to incorporate specific approaches to cost effectiveness.
2) The Plan can develop its ability to measure hospital performance and work with individual hospitals to improve their performance. Plans can develop data on costs, length of stay, productivity, billing cycles, etc., which can point to problems. If handled with sensitivity, hospital executives can be expected to welcome information which identifies variation from norms and suggests corrective action. In our visits, several hospital executives pointed out that Blue Cross Plans had helped them deal with internal professional pressures by demonstrating that practices deviated from community norms. A few Plans have developed sophisticated programs in this area and have added a management consultation capacity to help solve problems.
3) The basic source of improved hospital performance ideally originates within individual hospitals and their associations, but Plans can do much to stimulate and support local efforts. Local equivalents of ACHA type efforts to improve management, and other standard setting and monitoring efforts can be energetically pursued.

Joint Programs. The potentials for new linkages between financing and delivery agencies in all areas — benefit development, alternate delivery systems, more efficient administrative arrangements, data developments, productivity measurement, etc. — are higher than at any previous time. Such joint action has received relatively little attention and is an underdeveloped area. State and local hospital associations are increasing in size and expertise and can be a source of ideas and energy.

Hospital Organization of its Blue Cross Plan Relationship. This is a relatively new notion and some experimentation and demonstration projects can be stimulated by Blue Cross Plans. As with the Blue Cross Plan, the hospital should be encouraged to designate one executive to oversee all facets of the Blue Cross Plan relationship. Individual hospital committees of administration, board and physician representatives meeting regularly with Plan executives could explore a whole range of opportunities.

Perhaps the Plan might select a few hospitals where good relationships prevail and organize some demonstrations in which Plan and hospital attempt to maximize the relationship by improving current efforts and adding new functions. For example, computers and business office functions could be more closely linked; Blue Cross Plan staff could be directly involved in the hospital's budget process; experiments with new benefits might be conducted involving the hospital medical staff, the Blue Cross Plan, Blue Shield and the subscribers in the institution's service area; health education programs could be designed and their influence measured; etc.

Blue Cross Plan Involvement with Agencies Impacting on Hospitals. The Plan should list the key public and private agencies impacting hospitals and health care in the community and make formalized liaison assignments. Board and committee service should be encouraged.

3. Blue Cross Plans should take steps to exert greater impact on the Blue Cross Association with respect to hospital relationships.

Mutual understanding between Plans and BCA concerning the dynamics of hospital interactions will require stronger initiatives on the part of the individual Plans. A more useful blending of local and national "know how" can only result from better communication concerning the role that BCA can play in strengthening a Plan's relationships with its hospitals.

The main thrust of hospital-Blue Cross Plan relations is at the Plan level; but BCA can be encouraged to assume leadership activities in a key supporting role. Its ability to perform appropriate national functions — setting the tone for local relationships; serving as a clearinghouse of information among the Plans; providing technical assistance and ideas to Plans; and making clear to government and interested outsiders the validity and productivity of local relationships which address problems in the public interest — is dependent on strong, continuing Plan interaction, support and sharing of local successes and failures. BCA's ability to represent the organization and its effectiveness in this area are vital to future Blue Cross Plan and Association roles under public and private programs.

Plans with good programs have been too modest. Impressive local operations exist that are not well known within the organization. BCA can carry out its national clearinghouse and consultation roles only if individual Plan personnel are active in describing their own Plan's merits, advocating their own points of view and exerting more active influence on BCA staff and staff activities.

Blue Cross Plan representatives can participate more actively in the evolution of BCA policies and programs by serving on BCA committees, by developing case studies describing local programs, by passing on constructive criticisms of BCA efforts and by mobilizing local administrators in support of national Blue Cross Association policy.

A Word to Hospital Executives

Interest in the Blue Cross organization is understandably high and it is anticipated that this report will reach beyond the Blue Cross Association and Plan audiences to hospital executives. A word to them is in order.

Hospital leaders are urged to think through the alternatives to a rededication to a broader and deeper relationship with Blue Cross Plans in the community interest. In the absence of commitment by a critical mass of hospital leaders to a renewed dynamic Blue Cross Plan relationship, isn't it likely that the Blue Cross organization will be forced into an adversary role, a role as government's agent or a limited technical systems role that will force government to act much more aggressively?

As the forces to "do something" about problems of cost, access and effectiveness become even stronger, will the current bureaucratic frustrations, drift and milling about at the government level continue? Will the scope of exciting managerial initiatives be reduced by diversion of energy to coping with increasingly rigid rules and regulations? Or can Blue Cross Plans and hospitals work together creatively to design approaches with a more sensitive blend of discipline and flexibility, within an appropriate balance of government and private initiatives? Some hospital executives may not enjoy the vision of having a sophisticated Blue Cross Plan playing a much larger role in shaping health care delivery, but alternatives are even less palatable.

Hospital leaders who recognize the importance of a revitalized Blue Cross Plan-hospital relationship serving the public interest have unusual opportunities — even obligations — for professional initiative at this time. Within

the local Blue Cross Plan, their impact can be most significant in demonstrating the validity of the interdependent approach to other professionals who have become cynical. They can identify specific opportunities for joint action. At their own hospitals, there will be much work to be done with trustees, medical staff, administrative staff, fiscal officers and others to rekindle a belief in working together on the public's problems with the community's nonprofit hospital financing agency. They can set an example to the community in administering a sound Blue Cross benefit package for hospital employees and their dependents, and advocate Blue Cross benefits in all contacts with hospital trustees, other employers, union leaders and other community leaders.

At the hospital association, hospital leaders will have opportunities to exert influence in updating policy and encouraging a renewed spirit of cooperation and joint action with Blue Cross Plans. A few key hospital leaders active in each Plan area can assure a rededication to interdependent public service goals by hospitals and Blue Cross Plans and a sound balance between the private sector (with its special capacity for innovation and adaptation to diversity) and the public sector (with its special capacity to assure equity in allocation of scarce resources and compliance with basic standards).

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